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Men, Masculinity and Male Gender Role Socialisation: Implications for Men's

Mental Health and Psychological Help Seeking Behaviour

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of Male Gender Role Socialisation and Male Development on Men's Help Seeking for
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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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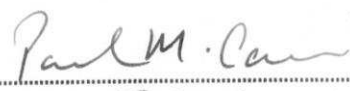
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STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Summary of Major Research Project

The major research project comprises of three sections

Section A: Literature review

This section reviews men's underutilisation of professional health care services and brings together the extant literature on men's help seeking for psychological difficulties. This is discussed specifically in relation to theories of male gender role socialisation and male development.

Section B: Empirical Paper

This section provides a report of an empirical quantitative study that investigated the relationships between masculinity, alexithymia, fear of intimacy and men's attitudes towards seeking professional psychological help, in a sample of men from the UK general population. All three predictor variables were associated with men's attitudes towards seeking professional psychological help. However, alexithymia and intimacy accounted for the same variance in help seeking, with alexithymia the strongest predictor. The findings are discussed in relation to the existing literature and implications and limitations considered.

Section B: Critical Review

This section provides critical appraisal and reflection on the study and research process. Personal learning is discussed alongside clinical implications and ideas for further research.

Men's Underutilisation of Mental Health Services and the Implications of Male Gender Role

Socialisation and Male Development on Men's Help Seeking for Psychological Difficulties:

A Review of the Literature.

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Abstract

There is growing recognition that the mental health needs of men are in need of attention. Men's underutilisation and reluctance to seek help and access health care services is a primary issue related to poorer health outcomes for men in the UK. Male gender role socialisation theories and theories of male development have been linked with men's help seeking for psychological difficulties.

A systematic literature search of men's help seeking was carried out on the Ovid-SP databases, Medline, CCCU Journals, EBM reviews, CINAHL and Google scholar. Literature related to men's help seeking for psychological problems forms the main analysis.

Male development and socialisation into gender roles may have significant implications for men's emotional and interpersonal development. The research reviewed suggests that male development and gender role socialisation influences men's attitudes towards seeking professional psychological help. This may partially account for men's underutilisation of mental health services.

Research in the US has relied mainly on correlational studies using undergraduate students, whilst research in the UK is limited to qualitative studies. How to increase men's voluntary use of services and legitimise help seeking for men needs further research. Men's emotional and interpersonal development needs to be integrated into a psychology of men and masculinity.

Contents

Men's Underutilisation of Mental Health Services and the Implications of Male Gender Role Socialisation and Male Development on Men's Help Seeking for Psychological Difficulties: A Review of the Literature

There is a growing recognition that there is a lack of information available about the physical and mental health of men and boys (Addis & Cohane, 2005; Baker, 2002; Men's Health Forum [MHF], 2006a, 2010, 2011; Mind, 2009). Average life expectancy from birth is four years less for men than it is for women, and across the lifespan men are at greater risk from nearly all major illnesses and injury (O'Brien & White, 2003; Courtenay, 2009; Coalition on Men & Boys, 2009). In the UK, men die younger across all age groups and experience cancer, heart disease and human-immunodeficiency virus at higher rates (DoH, 2002). They engage in many more behaviours that are a risk to their health (Courtenay, 2000), make up the vast majority of the prison population (Prison Reform Trust, 2005) and those who are homeless (Gill, Meltzer, Hinds & Pettcrew, 1994), suffer more substance abuse and dependence (Kessler et al. 2005) and are three times more likely to take their own lives through suicide (NIMHE, 2008).

Men's Mental Health

Diagnosed mental disorder in school age children (ages 5-15) is markedly more common in boys than in girls (MHF, 2010). Boys are diagnosed with more developmental difficulties than girls, including autistic spectrum disorders, specific learning disabilities and speech, language and communication problems (Kraemer, 2000; MHF, 2010). Boys are four times more likely to be diagnosed with behavioural, emotional or social difficulties and three times more likely to be given the label of attention deficit hyperactivity disorder (ADHD) (Ford, Goodman & Meltzer, 2003; NICE, 2006). Oppositional defiant disorder and conduct

disorder, which often coexists with ADHD (NICE, 2006), are diagnosed more often in boys. The high referral rate of young boys to Child and Adolescent Mental Health Services in the UK, has been attributed to the problems schools have managing boys' disruptive behaviour (Myttas, 2001; MHF, 2010).

Suicide is the most common cause of death in men under 35 and is the most widely acknowledged problem associated with men's mental health (DoH, 2002). Although there has been an ongoing downward trend, suicide rates for men are three times greater than they are for women (NIMHE, 2008). Approximately half of all those who commit suicide may also suffer from depression (MHF, 2002, 2010).

Internationally, women are diagnosed with depression more than men (NHS Information Centre, 2009; ONS, 2000; World Health Organisation [WHO], 2001), which the WHO (2001) has described as one of the most robust findings in psychiatric epidemiology. In the UK, the Acute National Morbidity Survey 2007 (NHS information centre, 2009) found that one in eight men compared to one in five woman met the diagnostic criteria for a common mental health problem.

Some authors have claimed that depression is under-diagnosed in men (Addis, 2008; Branney & White, 2008; Conrad & White, 2010). One possible explanation is that men in psychological distress display more externalising behaviours than women, including violent and aggressive acts and greater drug and alcohol misuse (WHO, 2001; Brownhill, Wilhelm, Barclay & Schmied, 2005; MIND, 2009). For some people, such behaviours may be symptomatic of underlying untreated common mental health difficulties but do not meet current diagnostic criteria (Addis, 2008). Consequently, the focus of interventions is usually

aimed at the problem behaviour rather than a possible underlying psychological problem. Indeed, men with dual diagnoses have traditionally been excluded from mental health services until the substance misuse has been addressed (CSIP, 2008).

Men who externalise their psychological distress may attract a less empathic response, risk exclusion from traditional mental health services and experience more coercive interventions or increased attention from the criminal justice system. Ninety-four percent of the prison population are men and 90 percent of prisoners are believed to have a mental health problem of some kind (Prison Reform Trust, 2005). Men make up the vast majority of homeless people, where the rates of mental illness are high (Gill, Meltzer, Hinds & Pettcrew, 1996), and men are more likely to develop drugs and alcohol difficulties (CSIP, 2008). Traditional services often fail to reach many groups of men (Conrad & White, 2010), whilst men themselves may be reluctant to seek help from professionals when faced with mental and physical health problems (White, 2001).

Men and Health Service Utilisation in the UK

Men show more sporadic and infrequent use of health care services, lack engagement with health material and show a tendency to delay seeking help when faced with health problems of significant concern (White, Fawkner & Holmes, 2006). UK statistics indicate that, men visit their doctors less frequently than women with the exception of the very young and the very elderly where consultation rates are similar (ISD, 2000; ONS, 2004; NHS Information Centre, 2009; The Scottish Government, 2009). Women aged between 15 and 44 are twice as likely to visit their GP as men of a similar age (particularly for 'minor'

symptoms) and are more likely to be referred for psychological therapy (ISD, 2000; ONS 2000).

A review of progress made by the Improving Access to Psychological Therapies (IAPT) programme showed that men are not accessing psychological therapies at the primary care level as frequently as women. The ratio was just under two women to every one man. The ratios were greater at both age extremes and lowest for people between the ages of 45-54 (Glover, Webb & Evison, 2010; Table 1).

Table 1

North East Public Observatory Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year

Age group	Female	Male	Total	Gender Ratio (F/M)
5 - 17	1%	1%	1%	2.8
18 – 24	14%	11%	13%	2.4
25 – 34	23%	22%	23%	2.1
35 – 44	23%	25%	24%	1.8
45 – 54	17%	19%	18%	1.7
55 – 64	9%	10%	10%	1.8
65 – 74	3%	3%	3%	2.3
75 - 84	1%	1%	1%	2.4
Age group missing	8%	8%	8%	1.9
Total	51109	26226	79310	1.9

Men become more visible in secondary care mental health services (ONS, 2010) where they are twice as likely to be placed on community treatment orders and make up the

vast majority of those detained as mental health inpatients due to prison and court referrals (NHS Information Centre, 2010). Specific groups of men, such as those from African and Caribbean backgrounds, are more likely to be placed on community treatment orders (NHS Information Centre, 2010) and come into contact with mental health services via the police and criminal justice system more frequently (Keating, 2007). During 2006-2007, 140,000 men used a drug treatment service compared to 55,000 women (NHS Information Centre, 2008).

The figures presented here may indicate that men use less preventative mental health strategies than women and are more likely to come into contact with services when problems are more severe, if at all. They may also represent a less voluntary use of services and a greater reluctance to seek help from traditional mental health services. Indeed, a scoping study on men's health carried out by White (2001) revealed men's reluctance to access health care services was a primary issue related to poorer health outcomes for men in the UK.

Rationale and Structure of the Review

Men underutilise professional health care services and have poorer health outcomes compared to women. Seeking help is an important factor associated with health outcomes and has been identified as a primary issue related to men's physical and mental health. This review examines the help seeking literature with a particular focus on men's help seeking for psychological difficulties from mental health professionals. More specifically, common factors affecting help seeking will be explored and sex differences identified before examining in depth factors specific to the male experience. Gender role socialisation theories

and theories of male development will be explored in relation to men's help seeking for psychological problems.

Help Seeking

Help seeking encompasses a complex set of issues and occurs when people are confronted with problems that demand more resources than they alone can provide (Gourash, 1978). Help seeking can be defined as any communication about a problem that is directed toward obtaining support, advice, or assistance in times of distress. This could be from friends, families, colleagues or neighbours as well as professional helping agencies. Seeking help from health professionals occurs less frequently than other forms of help seeking (Gourash, 1978; Timlin-Scalera, Ponterotto, Blumberg, & Johnson, 2003) and many people with mental disorders report not using professional health care services (Regier et al, 1993; Bebbington, 2000; Demyttenaere et al, 2004). The vast majority of people with mental disorders do not receive treatment (Kessler et al., 2005). Bebbington (2000) noted that only 30 percent of people with a mental health problem in the UK had consulted a mental health professional. Similarly, in a European survey of individuals from six European countries, only one in four adults with a mental health problem consulted mental health services (The ESEMeD/ MHEDEA 2000 Investigators, 2004).

Common Factors Affecting Help Seeking

One of the most common reasons for not seeking help for psychological difficulties is related to stigma attached to mental illness (Vogel & Wade, 2009). The threat to an individual's self worth and how the person perceives the act of seeking help is also of

importance (Vogel, Wade & Haake, 2006). People from different ethnic groups show different help seeking attitudes (Abramowitz & Murray, 1983; Gonzalez, Alegria & Prihoda, 2005) and across ages help seeking varies (Gonzalez et al., 2005). Illness perceptions impact on help seeking behaviour (Leong & Zachar, 1999) as does a person's locus of control (Fischer, 1970). Education has been associated with help seeking (Tijhuis, Peters & Foets, 1990) as have individual coping styles (Skeate, Jackson, & Jones, 2002) and self-concealment (Cepeda-Benito & Short, 1998).

Sex Differences in Help Seeking

One of the most common findings in the help seeking literature shows that females are more likely to seek help for mental and physical health problems than males (Addis & Mahalik, 2003; Blazina & Watkins, 1996; Good, Dell & Mintz, 1989; McKay, Rutherford, Cacciola & Kabasakalian-McKay, 1996; Mahalik, Good & Englar-Carlson, 2003; Padesky & Hammen, 1981; Thom, 1986; Willis, Fabian & Hendershot, 2005). Men of different ages, nationalities, and ethnic backgrounds seek help from mental health services less frequently than women from comparative groups (Addis & Mahalik, 2003; Gove, 1984; Gove & Tudor, 1973; Greenley & Mechanic, 1976; Howard & Orlinsky, 1972; Vessey and Howard, 1993). Whilst sex differences are helpful in highlighting men's underutilisation of services they tell us very little about within group differences or the underlying biological, psychological, or cultural processes (Addis & Mahalik, 2003; Mechanic, 1978). Moreover, male versus female comparisons run the risk of supporting essentialist interpretations of gender (Addis & Mahalik, 2003).

Men and Help Seeking

Psychological and social factors appear to have the greatest impact on men's help seeking behaviour (Doyal, Payne & Cameron 2003; Courtenay, 2003, 2009; MHF, 2010) with many authors claiming that men's help seeking behaviour can be directly related to the social construction and cultural representations of masculinities (Addis & Mahalik, 2003; Courtenay, 2009; COMAB, 2009; Lee & Owens, 2003; MHF, 2010). Good et al. (1989) noted with surprise how little attention had been given in the help seeking literature to male gender roles given they appear to be "intuitively antithetical to the behaviour of help seeking" (Good et al., 1989, p295).

Men who could benefit from professional help may choose not to pursue it because many aspects of psychological help seeking are in direct conflict with dominant masculine gender roles. Psychological therapies often emphasise traits such as emotional expression, introspection, intimacy, and acknowledgement of vulnerability, which may account for fewer men using psychological interventions (Brooks, 1998; Pollack & Levant, 1998; Rochlen, 2005). In the development and evaluation of the Barriers to Help Seeking Scale with 537 undergraduate males from the US, Mansfield, Addis, and Courtenay (2005) identified five barriers specific to men's help seeking, including; the need for control and self reliance; minimising problems and self resignation; concrete barriers and distrust of caregivers; privacy; and emotional control.

Gender Roles Socialisation

Gender-role socialisation theories posit that social environments teach men and women distinct sex-type behaviours and attitudes that influence how they see themselves in

relation to their gender and how they perceive the expectations for their behaviour (Mansfield, Addis & Mahalik, 2003). Gender roles are self-replicating with each generation being socialised into them by the generation before (Conrad & Warrick-Booth, 2010). Rather than being fixed, gender roles are considered to be multiple, transient and change over time and context with different generations exerting their influence in shaping the meaning of what it means to be male and female (Connell & Messerschmidt, 2005). Two popular areas of research into male gender socialisation theories have focused on gender ideologies and gender role conflict (Mansfield, Addis & Mahalik, 2003).

Masculine ideologies

Joseph Pleck (1981, 1995) proposed a common constellation of standards and expectations associated with the traditional male role in the US and other Western societies, which he referred to as 'traditional masculine ideology'. Connell (1995) coined the term 'hegemonic masculinity' to refer to a similar ideal of male behaviour, which privileges the dominant position of some men and for which men are strongly encouraged to aim. Such masculinities are seen to characterise traits such as physical strength, wealth, professional success, power, risk taking, invulnerability, virility, stoic emotionality, control, dominance, excessive competitiveness and a rejection of femininity. These terms will be used interchangeably throughout this review.

These models of masculine ideology have been criticised because they fail to account for relational aspects of masculinity (Bergman, 1995). Masculine ideologies are multiple and vary between people and groups. They are constantly changing based on the meanings constructed through relationships with ourselves, others and the world (Kimmel, 1994, 2000).

Pattman, Phoenix & Frosh (2005) carried out a large scale qualitative research project with 245, 11-14 year-old boys from twelve London secondary schools. They interviewed boys individually, and in mixed and single sex groups. In the single sex groups boys displayed and performed versions of masculinities and positioned themselves in opposition to versions of femininity. In mixed gender groups they were able to challenge inconsistencies between masculinity and behaviour, whilst during individual interviews they spoke more movingly about relationships, emotions and difficulties associated with the masculine self.

Although multiple masculinities exist there appears to be a more dominant form of masculinity ideology, which even if people do not ascribe to, they appear to measure themselves against (Pattman et al., 2005; Frosh, Phoenix & Pattman, 2002; O'Brien, Hunt & Hart, 2005; Timlin-Scalera et al., 2003). In a grounded theory study of help seeking in White male high school students from middle to upper income backgrounds, Timlin-Scalera et al. (2003) described how the need to fit in dictated help seeking behaviours in this population. This was similar to findings from focus groups with men from the UK (O'Brien et al., 2005). Pattman et al. (2005) proposed that certain aspects of hegemonic masculinity functioned as a method of social regulation in the young boys they interviewed. Even though many of the boys did not ascribe to these values (particularly during individual interviews) they often measured themselves and others against them.

Gender role strain

Pleck (1995) proposed that violating gender role stereotypes was common and could lead to a real or perceived social condemnation and negative evaluations from others. He suggested that how men feel about themselves may be dependent on how well they conform

or believe they conform to masculine gender norms (Pleck, 1995). Related to Pleck's (1981; 1995) gender role strain paradigm is O'Neil's gender role conflict theory [GRC] (O'Neil, 1981). GRC is defined as, "a psychological state in which socialised gender roles have negative consequences for the person or others [and] occurs when rigid, sexist or restrictive gender roles result in restriction, devaluation or violation of others or self" (O'Neil, 2008; p 362). GRC is theorised to result in restrictive emotionality; health care problems; obsession with achievement and success; restrictive sexual and affectionate behaviour; socialized control, power and competition issues; and homophobia (O'Neil, 2008).

Gender role socialisation and men's help seeking

Hegemonic masculine norms, values and ideologies are believed to undermine men's health and conflict with many of the tasks associated with seeking professional psychological help (Courteney, 2000; Calasanti, 2004). Having to rely on others, admitting and recognising that there may be a problem and addressing emotional difficulties do not fit well with masculine scripts that promote strength, independence, invulnerability and winning (Mahalik, Good & Englar-Carson, 2003). Levant (1990) suggests that there are four factors embedded in male gender role socialisation that contribute to men's negative attitudes towards therapy: difficulty admitting that a problem exists; difficulty asking for help; selectivity and difficulty identifying emotional states; and a fear of intimacy.

Research in the US using correlational designs has consistently shown that men who experience higher levels of GRC also endorse more negative attitudes towards help seeking (Blazina & Marks, 2001; Blazina & Watkins, 1996; Good, et al., 1989; Good & Wood, 1995; Lane & Addis, 2005; Mendoza & Cummings, 2001; Simonsen, Blazina & Watkins, 2000;

Wisch, Mahalik, Hayes & Nutt, 1995). All but one of these studies (Mendoza & Cummings, 2001) found that GRC was significantly associated with more negative attitudes towards seeking psychological help. Men who endorse higher degrees of traditional masculine ideology have also been shown to have more negative attitudes towards psychological help seeking. In a correlational study of 155 adult men in the US Berger, Levant, McMillan, Kelleher and Sellers (2005), found that men's attitudes towards psychological help seeking were more closely related to traditional masculine ideology than to GRC (Berger et al. 2005).

Qualitative research in the UK suggests that hegemonic masculine ideology may also be an important factor associated with UK men's attitudes towards seeking professional help for physical and mental health problems. O'Brien et al. (2005) carried out 14 focus groups with a diverse group of 55 Scottish men. They found a widespread reluctance to seek help (or to be seen to be seeking help) because of the threat it posed to their masculinity; this was particularly prevalent in younger participants. Older men and those who had to seek help were able to challenge some of the unhelpful aspects of masculine ideology that delayed their own help seeking.

Male development and gender role socialisation

Negative outcomes of gender role socialisation have traditionally been hypothesised to exist with little consideration for the developmental and psychological processes through which they emerge (Addis & Cohane, 2003). In the following section we will look briefly at male developmental theories and research that may help to account for hypothesised emotional and interpersonal consequences of male gender role socialisation in later life. This will focus on men's emotional development from a social learning perspective and a fear of

intimacy from a psychodynamic viewpoint, both of which Levant (1990) hypothesised to be important factors related to men's negative attitudes towards psychological therapy.

The emotional socialisation of boys

Male gender role socialisation may mean that boys are socialised to minimise or ignore much of their emotional experience and as a consequence may become less able to recognise or process their emotions in later life (Fischer & Good, 1997; Levant, 1998; O'Neil, 1981). Whilst emotion is undoubtedly biologically influenced much of our emotional evaluation and expression is socially and culturally mediated (Fivush, Brotman, Buckner & Goodman, 2000; Lewis, 1992; Lutz & White, 1986). From an early age caregivers appear to conform to cultural gender norms and unwittingly respond differently to boys and girls, subtly reinforcing gender consistent expressions of emotion (Fivush et al., 2000; Adams, Kuebli, Boyle & Fivush, 1995; Kuebli & Fivush, 1992).

Parents have been found to display fewer and less intense facial expressions with baby boys during the first year of life (Malatesta, Culver, Tesman, & Shepard, 1989), discuss emotions less with their sons than with their daughters (Dunn, Brown & Beardsall, 1991), provide less detail regarding emotions in conversations with boys (Fivush et al., 2003) and emphasise and reinforce more 'masculine' emotions such as anger with boys and more 'feminine' traits with girls (Chaplin, Cole, & Zahn-Waxler, 2005). Girls tend to become more adept at reading both verbal and non-verbal emotions in others, expressing and communicating their own feelings and minimising anger, whilst boys tend to be better at maximising their hostility and anger and minimising emotions of vulnerability, guilt and fear (Maltz & Borker, 1982; Hall, 1987).

Men, emotion and psychological help seeking

Male clients may expect that they will be encouraged, or even demanded, to talk about emotions and explore the emotional context of their life experience during psychological work (Mahalik et al., 2003). However, gender role socialisation seems to encourage boys and men to ignore and devalue emotions and many men may believe that feelings are unnecessary and better left unexplored (Mahalik et al., 2003; O'Neil, 1981). Wisch et al. (1995) examined the impact of GRC and counselling technique with a sample of 164 male undergraduates. They showed videotapes of psychological interventions that were either emotion focused or cognition focused. Men who viewed the emotion focused sessions and scored high on GRC were less likely to indicate a willingness to seek help.

O'Neil (1981) hypothesised that men develop restrictive emotionality, which refers to difficulties in self disclosure, recognising feelings and processing the complexities of interpersonal life. Large scale self-report surveys with undergraduate students in the US have shown the restrictive emotionality factor of GRC to be the biggest predictor of men's negative attitudes towards psychological help seeking (Blazina & Watkins, 1996; Good et al., 1989; Lane & Addis, 2005; Roberton & Fitzgerald, 1992). Alexithymia refers to the inability to put emotions into words and is hypothesised to be a common and widespread condition in men (Sifneos, 1973; Levant, 1998). Contrary to their hypotheses, a correlational study of men from the US did not find that alexithymia was associated with attitudes toward psychological help seeking (Berger et al., 2005). The authors propose that this finding may have been due to the absence of a measure of normative alexithymia as opposed to the measure of clinical alexithymia used in the study.

A psychodynamic theory of intimacy in men

Psychodynamic theories of male development have focused on the early years of men's lives (Chodorow, 1978; Diamond, 2004; Fast, 1990; Greenson, 1968; Ogden, 1989; Pollack, 1995; Stoller, 1964, 1965, 1968) and have led to the hypothesis that young infant boys experience a "normative gender-linked developmental trauma" at a pre-oedipal stage (Pollack, 1995). This potentially traumatising separation-individuation process can be mediated through formative interactions with both care-givers (Fast, 1990; Diamond, 2004). The hypothesised implication of a forced early separation-individuation is that many men go on to suppress the extent to which they allow themselves to care for and connect with others (Addis & Chahane, 2005; Mahalik et al., 2003; Pollack, 1995, 1998). Pollock (1998) believed this fear of intimacy is driven by a repressed fear of re-traumatisation, leading men to fend off affiliation and intimacy with others.

Reis (1998) reviewed several meta-analyses and concluded that there were substantial, robust and consistent findings to indicate that men tend to interact less intimately than women do. These findings were both stronger and more consistent in same-sex than opposite-sex relationships. Men's relationships were also found to be substantially less intimate than those of women. Restrictive gender role socialisation has been linked to problems of sociability and intimacy in men (Sharpe, Heppner & Dixon, 1995), less satisfaction in marital relationships (Shape et. al., 1995; Campbell & Snow, 1992) and low relationship satisfaction (Campbell & Snow, 1992). Men who report greater GRC also report a greater fear of intimacy (Fischer & Good, 1997).

Men, intimacy and help seeking

Intimacy is an interactional process in which one's innermost core is made at least partly accessible to another (Reis, 1998). Traditional psychological therapy involves a close relationship with a therapist and the disclosure of information that is personal. However, little attention has been given to intimacy as a predictor of men's attitudes towards seeking psychological help.

Associated with intimacy is the masculine ideology of independence, which may signify a discomfort with needing assistance from others, including health care professionals (Mahalik et al., 2003). In the development of the Barriers to Help Seeking Scale Mansfield et al. (2005) found that, within a sample 58 undergraduate men in the US, those who reported more self-reliance showed less willingness to seek psychological help. They concluded that self-reliance was an important psychological process related to help seeking in men. Focus groups carried out by Ritchie (1999) found that young men from the UK had difficulty accessing confiding relationships with male friends for emotional difficulties. Indeed, men often report having fewer social support networks than women (Boreham, Stafford & Taylor, 2000; Pevalin & Rose, 2003), which may be related to an avoidance of forming close attachments (MHF, 2006a).

Discussion

Psychological research through the years has often positioned the white, male, heterosexual, middle class, employed and able bodied man as normative with only those who differ in need of investigation and correction (Harding, 1986; Lee & Owens, 2002, 2005). Indeed, until recently men's reluctance to seek help was not seen as problematic but normative and reflective of an overutilisation of services by women (Courtenay, 2000). Men's reluctance to seek help is now considered to be one of the biggest factors affecting the physical and mental health of men in the UK (White, 2001). Masculine gender role socialisation and male development offer some explanation as to why men may be reluctant to seek professional help for psychological difficulties.

Most of the research reviewed here has been carried out in the US where there has been an established interest in men's mental health over the last 30 years. However, research from the US has mainly relied on correlational studies and survey methodologies to examine individual differences in men's attitudes towards psychological help seeking. This reliance on correlational studies means that causality cannot be inferred and the results say little about the reasons why these relationships exist. Only one of the studies reviewed (Berger et al., 2005) sampled from the general population, whilst the others used convenience sampling of undergraduate students. The generalisability of findings is limited and given that younger men report more negative attitudes towards psychological help seeking (O'Brien et al., 2005; Berger et al., 2005) the results may represent a type I error. Only one qualitative study from the US was found, which used grounded theory to explore help seeking behaviours in a homogeneous group of affluent young men (Timlin-Scalera et al., 2003).

Research in the UK has relied on qualitative methodologies to explore men's help seeking attitudes. The results support findings from the US which link traditional masculine ideology with men's help seeking behaviour (Galdas, Cheater & Marshall, 2005; O'Brien, Hunt & Hart, 2005; Ritchie, 1999; White, 2001). These qualitative studies add richness to the data and demonstrate the complex relationships between masculinity and help seeking within different groups of men. However, to date no quantitative studies have been conducted to see if these findings are generalisable to the wider UK population and further research is needed. Specific groups of men who are reluctant to seek help also need to be identified.

Research into masculinity and men's help seeking has been criticised for its focus on traditional hegemonic forms and much less is known about more marginalised masculinities (Bergman, 1995; Kimmel, 1994, 2000). Qualitative studies have enhanced our understanding of how masculinities are multiple and socially constructed. They offer insight into how different groups of men and individuals construct and reconstruct masculinities. Understanding how different individuals and groups of men overcome the challenges of seeking help in relation to their masculine self will be an important area of future research and may help to identify possible strategies to facilitate help seeking in men.

The studies reviewed here focused primarily on men's attitudes towards seeking help. Whilst attitudes towards seeking help are considered to be a precursor to actual help seeking behaviour (Ajzen, 1985, 1981), they do not tell us about men's actual help seeking behaviour or their intentions to seek help. There is some evidence to indicate that attitudes towards psychological help seeking mediate intentions to seek help but more research is needed (Smith, Tran & Thompson, 2008). Whilst research into men's help seeking attitudes is

important such research is problematic in that it locates the problem within the individual. The attitude of services towards men and boys may be equally important in accounting for men's reluctance to seek help. For example, one consequence of reacting to the problematic behaviours of men and boys, at the expense of their underlying psychological distress, may be that strained relationships develop between men and services. This could be an interesting area of future research.

Emotional difficulties and a fear of intimacy in close relationships are considered important factors related to men's negative attitudes towards psychological therapy (Levant, 1990). Whilst the restrictive emotionality dimension of GRC has been found to be associated with men's help seeking behaviour (Blazina & Watkins, 1996; Good et al., 1989; Lane & Addis, 2005; Roberton & Fitzgerald, 1992), alexithymia has not (Berger et. al, 2005). Although self-reliance has been shown to be associated with less willingness to seek help (Mansfield et al., 2005), no studies were found that investigated how a fear of intimacy in men relates to their help seeking behaviour. These implications of male gender role socialisation have traditionally been hypothesised with little reference to the psychological processes through which they develop. Social learning and psychodynamic theories of male development provide some theoretical foundation to account for how these difficulties emerge in later life. Sex differences in emotional experience and intimacy provide further evidence to support these theories. However, theories of male development need to become incorporated into a psychology of men and masculinity (Addis & Cohane, 2005)

NHS organisations have a legal duty to address health inequalities and understand the impact of their work on men and women as distinct groups (MHF, 2006b). Men in the UK

appear reluctant to access psychological therapies for less severe symptoms. Clinical psychologists may be well placed to address this underutilisation and begin developing strategies that address this unmet need and reach out to men who are reluctant to seek help. Understanding the ways in which men come to the decision to seek help, and initiate actual help seeking may enable strategies to be developed that encourage men to access services. Understanding more about how masculinities are adaptively constructed and reconstructed to facilitate help seeking could help to identify strategies that normalises help seeking for men. For example, media campaigns such as 'Men on the Ropes' (Samaritans, 2010) aim to legitimise help seeking by portraying it in a way that challenges unhelpful masculine norms and positively reconstructs help seeking within the confines of a masculine code. Experimental designs could help to provided evidence for the effectiveness of strategies that aim to alter the help seeking attitudes of men and boys.

Mental health services may need to rethink how they deliver services to men and improve men's motivation to seek help. Moving beyond traditional psychological therapy may help services reach more groups of men. Services and the interventions they offer may need to be marketed in a way that is acceptable to men who are resistant to traditional forms of therapy (Addis & Cohane, 2005; Rochlen & Hoyer, 2005). However, there is currently little empirical evidence that supports the effectiveness of interventions that are specific to men and tackle men's reluctance to seek help (McKelley & Rochlen, 2005).

Conclusion

Traditionally, the mental health needs of men have been overlooked and their help seeking behaviours considered normative. Men's reluctance to seek help is now considered to be the biggest factor associated with poorer health outcomes for men in the UK. Research indicates that the social construction of dominant masculine ideology is associated with men's negative attitudes towards seeking professional psychological help. Theoretical consequence of male development may mean that boys grow into men who struggle emotionally and interpersonally, both of which may be important factors related to men's attitudes towards psychological help seeking. Strategies which motivate men into seeking help, and legitimise and normalise help seeking for men will be important in addressing their specific mental health needs. A more gender sensitive approach to understanding men's psychological health is needed.

References

Adams, S., Kuebli, J., Boyle, P.A., & Fivush, R. (1995). Gender differences in parent-child conversations about past emotions: A longitudinal investigation. Sex Roles, 33, 309-323.

Addis, M.E. (2008). Gender and depression in men. Clinical Psychology: Science and Practice, 15, 153-168.

Addis, M.E., & Cohane, G.H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men's mental health. Journal of Clinical Psychology, 61, 633-647.

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. American Psychologist, 58, 5-14.

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhi & J. Beckmann (Eds.), Action.control: From cognition to behavior (pp. 11-39). Heidelberg: Springer.

Ajzen, I. (1991). The theory of planned behaviour. Organizational Behavior and Human Decision Processes, 50, 179-211.

Baker, P. (2002). The European men's health forum. *Men's Health Journal, 1* (2), 43.

Baron-Cohen, S. (2003). The essential difference. London: Allen Lane.

Bebbington, P. (2000). The need for psychiatric treatment in the general population. In G. Andrews & S. Henderson (Eds.), Unmet need in psychiatry (pp. 85-96). Cambridge: Cambridge University Press.

Berger, J.M., Levant, R.F., McMillan, K.K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculine ideology, alexithymia, and age on men's attitudes towards psychological help seeking. Psychology of Men and Masculinity, 6, 73-78.

Bergman, S.J. (1995). Men's psychological development: a relational perspective. In R. Levant & W. Pollack (Eds.), A new psychology of men (pp 68-90). New York: Basic Books.

Blazina, C., & Marks, L.J. (2001). College men's affective reactions to individual therapy, psychoeducational workshops, and men's support group brochures: The influence of gender-role conflict and power dynamic upon help-seeking attitudes. Psychotherapy, 38, 297-305.

Blazina, C., & Watkins, C.E., Jr. (1996). Masculine gender role conflict: Effects on college men's psychological well being, chemical substance usage, and attitudes towards help seeking. Journal of Counseling Psychology, 43, 461-465.

Boreham, R., Stafford, M., & Taylor, R. (2000). Health survey for England: Social capital and health. London: The Stationary Office.

Brannon, R. (1976). The male sex role: Our culture's blueprint for manhood, what it's done for us lately. In D. David & R. Brannon (Eds.), The forty-nine percent majority: The male sex role (pp. 1–45). Reading, MA: Addison-Wesley.

Brody, L. R. (1996). Gender, emotional expression, and parent–child boundaries. In R. D. Kavanaugh, B. Zimmerberg, & S. Fein (Eds.), Emotion: Interdisciplinary perspectives (pp. 139–170). Mahwah, NJ: Erlbaum.

Brody, L.R., & Hall, J.A. (1993). Gender and emotion. In M. Lewis & J.M. Haviland (Eds), Handbook of emotions. New York: Guildford Press, 447-460.

Brooks, G. (1998). A new psychotherapy for traditional men. San Francisco: Jossey-Bass.

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). 'Big build': Hidden depression in men. Australian and New Zealand Journal of Psychiatry, 39, 921–931.

Calasanti, T. (2004). Feminist gerontology and old men. Journal of Gerontology, 59(6), 305-314.

Campbell, J.L., & Snow, B.M. (1992). Gender role conflict and family environment as predictors of men's marital satisfaction. Journal of Family Psychology, 6, 84-87.

Care Services Improvement Partnership. (2008). Mental health NSF autumn assessment 2007 - dual diagnosis themed review. London: Department of Health.

Cepeda-Benito, A., & Short, P. (1998). Self concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. Journal of Counseling Psychology, 45, 58-64.

Chaplin, T.M., Cole, P.M., & Zahn-Waxler, C. (2005). Parental socialisation of emotion expression: Gender differences and relations to child adjustment. Emotion, 5, 80-88.

Coalition of Men and Boys. (2009). Men masculinities and equality in public health. London: Coalition of Men and Boys.

Connell, R.W. (1995) Masculinities. Cambridge: Polity Press.

Connell, R.W., & Messerschmidt, J.W. (2005). Hegemonic masculinity: Rethinking the concept. Gender and Society, 19, 829-859.

Conrad, D., & Warwick-Booth, L. (2010). Cultural representations of masculinity and mental health. In D. Conrad & A. White (Eds) *Promoting men's mental health* (pp 18-25). Oxford: Radcliffe Publishing.

Conrad, D., & White, A. (Eds.). (2010). *Promoting men's mental health*. Oxford: Radcliffe Publishing.

Courtenay, W.H. (2000). Behavioural factors associated with disease, injury, and death among men: Evidence and implications for prevention. *Journal of Men's Studies, 9*(1), 81-142.

Courtenay, W.H. (2003). Key determinants in health and wellbeing of men and boys. *International Journal of Men's Health, 2,* 1-30.

Courtenay, W.H. (2009). Theorizing masculinity and men's health. In A. Broom & P. Tovey (Eds.), *Men's health: Body, identity and social context* (pp 9-32). London, UK: Wiley-Blackwell.

Chowdorow, N. (1978). The reproduction of mothering: Psychoanalysis and the sociology of gender. California: University of California Press.

Deane F.P., Skogstad P., & Williams M.W. (1999). Impact of attitudes, ethnicity, and quality of prior therapy on New Zealand male prisoners' intentions to seek professional

psychological help. International Journal for the Advancement of Counselling, 21, 55-67.

DeFrank, W., & Mahalik, J.R. (2002). Masculine gender role conflict and stress in relation to parental attachment and separation. Psychology of Men and Masculinity, 3, 51-60.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., et al (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. Journal of the American Medical Association, 291, 2581-2590.

Department of Health. (2002). National suicide prevention strategy for England. London: Department of Health.

Diamond, M.J. (2004). The shaping of masculinity: Revisioning boys turning away from their mothers to construct male gender identity. International Journal of Psychoanalysis, 85, 359-380.

Doyal, L., Payne, S. & Cameron, A. (2003). Promoting gender equality in health. London: Equal Opportunities Commission.

Dunn, J., Brown, J., & Beardsall, L. (1991). Family talk about feeling states and children's later understanding of others' emotions. Developmental Psychology, 27(3), 448–455.

ESEMeD/MHEDEA 2000 Investigators. (2004). Use of mental health services in Europe: Results from the European study of the epidemiology of mental disorders (ESEMeD) project. Psychiatrica Scandinavica, 109, 47-54.

Fast, I. (1984). Gender Identity. Hillsdale, NJ: Analytic Press.

Fast, I. (1990). Aspects of early gender development: Toward a reformulation. Psychoanalytic Psychology, 7, 105-117.

Fischer, A.R. (1970). Orientations to seeking professional help: Development of research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 35, 79-90.

Fischer, A.R. (2007). Parental relationship quality and masculine gender role strain in young men: Mediating effects of personality. The Counseling Psychologist, 35, 328-358.

Fischer, A.R., & Good, G.E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. Psychotherapy, 34, 160-169.

Fivush, R., Brotman, J.P., Buckner, J.P., & Goodman, S.H. (2000). Gender differences in parent-child emotion narratives. Sex Roles, 42, 233-253.

Fivush, R., Berlin, L. J., Sales, J. M., Mennuti-Washburn, J., & Cassidy, J. (2003). Functions of parent–child reminiscing about emotionally negative events. Memory, 11, 179–192.

Ford, T., Goodman, R., & Meltzer, H. (2003). The British child and adolescent mental health survey 1999: The prevalence of DSM-IV disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 42, 1203-1211.

Frosh, S., Phoenix, A., & Pattman, R. (2002). Young masculinities: Understanding boys in contemporary society. London: Palgrave.

Galdas, P.M., Cheater, F., & Marshall, P. (2005). Men and health help seeking behaviour: Literature review. Journal of Advanced Nursing, 49, 616-623.

Gill, B., Meltzer, H., Hinds, K., & Petticrew, M. (1996). OPCS survey of psychiatric morbidity in Great Britain, Report 7: Psychiatric morbidity among homeless people. London: OPCS.

Glover, G., Webb, M., & Evison, F. (2010). Improving access to psychological therapies: A review of progress made by sites in the first roll-out year. Stockton on Tees: North East Public Health Observatory.

Gonzalez, J.M., Alegria, M., & Prihoda, T.J. (2005). How do attitudes towards mental health treatment vary by age, gender, and ethnicity/race in young adults? Journal of Community Psychology, 33, 611-629.

Good, G.E., Dell, D.M., & Mintz, L.B. (1989). Male gender role conflict: Relations to help seeking in men. Journal of Counseling Psychology, 36, 295-300.

Good, G.E., & Wood, P.K. (1995). Male gender role conflict, depression, and help seeking: do college men face double jeopardy? Journal of Counselling and Development, 74, 70-75.

Gourash, N. (1978). Help seeking: A review of the literature. American Journal of Community Psychology, 6, 413-423.

Gove, W. R. (1984). Gender differences in mental and physical illness: The effects of fixed roles and nurturant roles. Social Science and Medicine, 19, 77–84.

Gove, W. R., & Tudor, J. F. (1973). Adult sex roles and mental illness. American Journal of Sociology, 78, 50–73.

Greenley, J. R., & Mechanic, D. (1976). Social selection in seeking care for psychological problems. Journal of Health and Social Behavior, 17, 249.

Greenson, R.R. (1968). Disidentifying from mother: Its special importance for the boy. International Journal of Psychoanalysis, 49, 370-374.

Hall, J. A. (1987). On explaining gender differences: The case of nonverbal communication. Review of Personality and Social Psychology, 7, 177-200.

Harding, S. (1986). The science question in feminism. Milton Keynes: Open University Press.

Haviland, J.J., & Malatesta, C.M. (1981). A description of the development of nonverbal signals: Fallacies, facts and fantasies. In C. Mayo & N. Henley (Eds.) Gender and nonverbal behaviour. New York Springer.

Hook, M.K., Gerstein, L.H., Detterich, L., & Gridley, B. (2003). How close are we? Measuring intimacy and examining gender differences. Journal of Counseling and Development, 81, 462-472.

Howard, K. E., & Orlinsky, D. E. (1972). Psychotherapeutic processes. Annual Review of Psychology, 23, 615–668.

Howerton, A., Byng, R., Campbell, J., Hess, C., Owens, C., & Aitken, P. (2007). Understanding help seeking behaviour among male offenders: Qualitative interview study. British Medical Journal, 334, 303-309.

ISD. (2000). Consultation rates per 1000 population. Scottish health statistics, section L1. Scotland: ISD.

Keating F. (2007). African and Caribbean men and mental health. London: Race Equality Foundation.

Kessler, R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, J.A., Walters, E.E., . . . Zaslavsky, A.M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. The New England Journal of Medicine, 352, 2515-2523.

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. The *Journal of Men's Health and Gender,* 2, 95-99.

Kimmel, M. (1994). Masculinity as homophobia: Fear, shame and silence in the construction of gender identity. In H.Brod & M.Kaufman (Eds.), Theorizing masculinities (pp. 119-141). California: Sage.

Kimmel, M.S. (2000). The gendered society. Oxford: Oxford University Press.

Kindlon, D. J., & Thompson, M. (2000). Raising Cain: Protecting the emotional life of boys. New York: Ballantine Books.

Kraemer, S. (2000). The fragile male. British Medical Journal, 321(7276), 1609-1612

Kring, A.M., & Gordon, A.H. (1998). Sex differences in emotion: Expression, experience and physiology. Journal of Personality and Social Psychology, 74, 686-703.

Kuebli, J., & Fivush, R. (1992). Gender differences in parent-child conversations about past emotions. Sex Roles, 27, 683-698.

Lane, J. M., & Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. Psychology of Men & Masculinity, 6, 155–168.

Lax, R.F. (1997). Boys' envy of mother and the consequences of narcissistic mortification. The Psychoanalytic Study of the Child, 52, 118-139.

Lee, C., & Owens, R.G. (2002). Issues for a psychology of men's health. Journal of Health Psychology, 7, 209-217.

Leong, F.T.L., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes towards seeking professional psychological help. British Journal of Guidance and Counselling, 27, 123-132.

Levant, R. (1990). Psychological services designed for men: A psychoeducational approach. Psychotherapy, 27, 309-315.

Levant, R. (1998). Desperately seeking language: Understanding, assessing, and treating normative male alexithymia. In W. Pollack & R. Levant (Eds.), New psychotherapy for men (pp. 35-56). New York: Wiley.

Levant, R.F., Richmond, K., Majors, R.G., Inclan, J.E., Rosello, J.M., Rowan, G., & Sellers, A. (2003). A multicultural investigation of masculinity ideology and alexithymia. Psychology of Men and Masculinity, 4. 91-99.

Levant, R.F., Good, G.E., Cook, S., O'Neil, J., Smalley, K.B., Owen, K.A., Smalley, K.B. (2006). Validation of the normative male alexithymia scale: Measurement of a gender linked syndrome. Psychology of Men and Masculinity, 7, 212-224.

Levant, R. F., Wimer, D.J, & Williams, C. M. (2011). An evaluation of the psychometric properties of the Health Behavior Inventory-20 (HBI-20) and its relationships to

masculinity and attitudes towards seeking psychological help among college men. Psychology of Men and Masculinity, 11, 26-41.

Lewis, M. (1992). The role of the self in social behavior. In F. S. Kessel, P. M. Cole, & D. L. Johnson (Eds.), Self and consciousness: Multiple perspectives (pp. 19–44). Hillsdale, NJ: Erlbaum.

Lutz, C., & White, G.M. (1986). The anthropology of emotions. Annual Review of Anthropology, 15, 405–436.

MacGeorge, E. L. (2003). Gender differences in attributions and emotions in helping contexts. Sex Roles, 48(3), 175-182.

Mahalik, J.R., Good, G.E., & Englar-Carson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. Professional Psychology: Research and Practice, 34, 123-131.

Malatesta, C.Z., Culver, C., Tesman, J.R., & Shepard, B. (1989). The development of emotional expression during the first two years of life. Monographs of the Society for Research in Child Development, 54, 105-136.

Maltz, D. N., & Borker, R. A. (1982). A cultural approach to male-female miscommunication. In J. Gumperz (Eds.), Language and social identity (pp. 195-216). Cambridge, England: Cambridge University Press.

Mansfield, A.K., Addis, M.E., & Courteney, W. (2005). Measurement of men's help seeking: Development and evaluation of the barriers to help seeking scale. Psychology of Men and Masculinity, 6, 95-108.

Mansfield, A.K., Addis, M.E., & Mahalik, J.R. (2003). "Why won't men go to the doctor?" The psychology of men's help seeking. *International Journal of Men's Health, 2,* 93-109.

McKay, J.R., Rutherford, M.J., Cacciola J.S., & Kabasakalian-McKay, R. (1996). Gender differences in the relapse of cocaine patients. Journal of Nervous and Mental Disease, 184, 616-622.

McKelley, R. A., & Rochlen, A. B. (2010). Conformity to masculine role norms and preferences for therapy or executive coaching. Psychology of Men and Masculinity, 11, 1-14.

Mechanic, D. (1978). Sex, illness behavior, and the use of health services. Social Science and Medicine, 12, 207–214.

Mendoza, J., & Cummings, A.L. (2001). Help-seeking and male gender-role attitudes in male batterers. Journal of Interpersonal Violence, 16, 833-840.

Men's Health Forum. (2002). Soldier it! Young men and suicide. London: Men's Health Forum.

Men's Health Forum. (2006a). Mind your head: Men, boys and mental wellbeing. London: Men's Health Forum.

Men's Health Forum. (2006b). The report of the gen*der equity project: What the 'Gender Duty' provision of the Equality Act 2006 will mean for the health of men.* London: Men's Health Forum.

Men's Health Forum. (2010). Untold problems: A review of the essential issues in the mental health of men and boys. London: Men's Health Forum.

Men's Health Forum. (2011). Delivering male: Effective practice in male mental health. London: Men's Health Forum.

Mind. (2009). Men and mental health: Get it off your chest. London: Mind.

Moffitt, T. E. (1993). "Life-course persistent" and "adolescent-limited" anti-social behaviour: A developmental taxonomy. Psychological Review, 100, 674–701.

Myttas, N. (2010). Understanding and recognising ADHD. Practice Nursing 12(7), 278-280.

NHS Information Centre. (2008). Statistics on drug misuse: England 2008. London: Department of Health.

NHS Information Centre. (2009). Trends in consultation rates in general practice 1995 to 2008: Analysis of the QResearch database. London: Department of Health.

NHS Information Centre. (2010). In-patients formally detained in hospitals under the mental health act 1983 and patients subjected to supervised community treatment, annual figures, England 2009/10. Retrieved from http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/inpatientdetmha0910/KP90_final_report.pdf

NICE. (2006). Parent-training/education programmes in the management of children with conduct disorders. London: NICE.

NIMHE. (2008) Suicide prevention strategy for England: Annual report on progress 2007. London: Department of Health.

O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. Social Science and Medicine, 61, 503-516.

O'Brien, O., & White, A. (2003). Gender and health: The case for gender-sensitive health policy in health care delivery (conference paper for 14 November 2003). Retrieved from http://www.emhf.org/resource_images/GaHP_Briefing_Paper.pdf

O'Neil, J. M. (1981). Male sex-role conflict, sexism, and masculinity: Implications for men women, and the counseling psychologist. The Counseling Psychologist, 9, 61-80.

O'Neil, J. (2008). Summarising 25 years of research on men's gender role conflict using the gender role conflict scale. The Counseling Psychologist, 36(3), 358-445.

Ogden, T.H. (1989). The primitive edge of experience. Northvale, NJ: Aronson.

Office of National Statistics. (2000). Key statistics from general practice 1998. London: The Stationary Office.

Office of National Statistics. (2004). Consultations with an NHS GP: By Sex and Age, 2001/02: Social Trends 34 2004. Retrieved from http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=7401&;More=Y

Office of National Statistics. (2010). Patterns of specialist mental health service usage in England. Retrieved from http://neighbourhood.statistics.gov.uk/HTMLDocs/images/Mental-Health-Service-usage-small-analysis1_tcm97-97434.pdf

Padesky, C.A., & Hammen , C.L. (1981). Sex differences in depressive symptom expression and help-seeking among college students. Sex Roles, 7, 309-320.

Pattman, R., Frosh, S., & Phoenix, A. (2005). Constructing and experiencing boyhoods in research in London. Gender and Education, 17(5), 555-561.

Pevalin, D., & Rose, D. (2003). Social capital for health: Investigating the link between social capital and health using the British household panel survey. London: Health Development Agency.

Pleck, J.H. (1981). The myth of masculinity. Cambridge, MA: MIT Press.

Pleck, J.H. (1995). The gender role strain paradigm: An update. In R.F. Levant & W.S. Pollack (Eds.), A New Psychology of Men (pp. 11-32). New York: Basic Books.

Pollack, W.S. (1995). No man is an island: Toward a new psychoanalytic psychology of men. In R. Levant & W. Pollack (Eds.), A new psychology of men (pp. 68-90). New York: Basic Books.

Pollack, W.S. (1998). The trauma of Oedipus: Toward a new psychoanalytic psychotherapy for men. In W.S. Pollack & R.F. Levant (Eds.), New Psychotherapy for Men (pp.13-34). Toronto: John Wiley & Sons.

Pollack, W. S., & Levant, R. F. (1998). New psychotherapy for men. New York: Wiley.

Prison Reform Trust. (2005). The prison factfile. London: Prison Reform Trust.

Regier, D. A.,Narrow,W. E., Rae, D. S., Mandersheid, R.W., Locke, B.Z., Goodwin, F.K. (1993). The de facto US mental and addictive disorders service system.

Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. Archives of General Psychiatry, 50, 85-94.

Reis, H.T. (1998). Gender differences in intimacy and related behaviours: Context and process. In D.J. Canary & K. Dindia (Eds.), Sex differences and similarities in communication: Critical essays ad empirical investigations of gender and interaction (pp. 203-232). Mahwah NJ: Erlbaum.

Ridley, J. (1993). Gender and couples: Do women and men seek different kinds of intimacy? Sexual and Marital Therapy, 8, 243-253.

Ritchie, D. (1999). Young men's perceptions of emotional health: Research into practice. Health Education, 2, 70-75.

Robertson, J.M., & Fitzgerald, L.F. (1992). Overcoming the masculine mystique: Preferences for alternative forms of assistance amongst men who avoid counseling. Journal of Counseling Psychology, 39, 240-246.

Rochlen, A. B. (2005). Men in (and out of) therapy: New directions and remaining challenges. Journal of Clinical Psychology, 61, 627– 631.

Rochlen, A. B., & Hoyer, W. D. (2005). Marketing mental health to men. Journal of Clinical Psychology, 61, 675–684.

Rochlen, A. B., Whilde, M.R., & Hoyer, W. D. (2005). The real men. Real depression campaign: Overview, theoretical implications, and research considerations. Psychology of Men and Masculinity, 6, 186-194.

Sabo. D., & Gordon D. F. (1995). Men's health and illness: Gender, power and the body. Thousand Oaks, CA: Sage.

Samaritans. (2010). Men on the ropes campaign. Retrieved from http://www.samaritans.org/support_samaritans/campaigns/boxer_campaign_2010/boxer_campaign_about.aspx

Sharpe, M.J., Heppner, P.P., & Dixon, W.A. (1995). Gender role conflict, instrumentality, expressiveness, and wellbeing in adult men. Sex Roles, 33, 1-18.

Sifneos, P.E. (1973). The prevalence of 'alexithymic' characteristics in psychosomatic patients. Psychotherapy and Psychosomatics, 22, 255-262.

Simonsen, G., Blazina, C., & Watkins, C.E. (2000). Gender role conflict and psychological well-being among gay men. Journal of Counseling Psychology, 47 (1), 85-89.

Skeate, A., Jackson, C., & Jones, C. (2002). Duration of untreated psychosis and pathways to care in first-episode psychosis. The British Journal of Psychiatry, 181, 72-77.

Stoller, R. (1964). A contribution to the study of gender identity. International Journal of Psychoanalysis, 45, 220-226.

Stoller, R. (1965). The sense of maleness. Psychoanalysis Quarterly, 34, 207-218.

Stoller, R. (1968). Presentations of gender, Vol. 1: The development of masculinity and femininity. London: Hogarth Press.

Tannen, D. (1990). *You just don't understand: Women and men in conversation*. New York: Morrow.

Thom, B. (1986). Sex differences in help seeking for alcohol problems: The barriers to help seeking. British Journal of Addiction, 81, 777-788.

Tijhuis, M.A.R., Peters, L., & Foets, M. (1990). An orientation toward help-seeking for emotional problems. Social Science and Medicine, 31, 989-995.

Timlin-Scalera, R.M., Ponterotto, J.G., Blumberg, F.C., & Jackson, M.A. (2003). A grounded theory study of help seeking behaviours among white male high school students. Journal of Counseling Psychology, 50, 339-350.

The Scottish Government. (2009). GP access survey; Results and methodology. Retrieved from http://www.scotland.gov.uk/Resource/Doc/277888/0083493.pdf

Vessey, J. T., & Howard, K. I. (1993). Who seeks psychotherapy? Psychotherapy, 30, 546–553.

Vogel, D.L., & Wade, N. (2009). Stigma and help seeking. The Psychologist, 22(1), 20-23.

Vogel, D.L., Wade, N., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. Journal of Counseling Psychology, 53, 325-337.

White, A. (2001). Report on the scoping study on men's health. London: HMSO.

White, A., Fawkner, H.J., & Holmes, M. (2006). Is there a case for differential treatment of young men and women? Medical Journal of Australia, 185(8), 454-455.

WHO (2001). Gender disparities in mental health. Retrieved from http://www.who.int/mental_health/media/en/242.pdf

Willis, S.P., Fabian, E.S., & Hendershot, G.E. (2005). Help seeking behavior among people

    with disabilities: Results from and national survey. Journal of Rehabilitation, 71, 42-

    48.

Wills, T. A., & DePaulo, B. M. (1991). Interpersonal analysis of the help-seeking process. In

    C. R. Snyder & D. R. Forsyth (Eds.), Handbook of social and clinical psychology (pp.

    350–375). Elmsford, NY: Pergamon.

Wisch, A.F., Mahalik, J.R., Hayes, J.A., & Nutt, E.A. (1995). The impact of gender role

    conflict and counselling technique on psychological help seeking in men. Sex Roles,

    33, 77-89.

Wood, J. T. (1997). Gendered lives: communication, gender, and culture (2nd Eds.).

    Belmont, CA: Wadsworth.

Masculinity, Alexithymia and Fear of Intimacy as Predictors of UK men's Attitudes Towards

Seeking Professional Psychological Help

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Abstract

Introduction

Men's reluctance to access health care services has been under researched even though it has been identified as a potentially important predictor of poorer health outcomes among men. Male gender role socialisation and male development may be important in accounting for men's underutilisation of mental health service in the UK.

Method

A cross-sectional online survey was used to administer standardised self-report measures that were subject to regression analysis. Five hundred and eighty-one men from the UK general population completed the survey and 434 participants formed the final regression model sample.

Results

Men who score higher on measures of traditional masculine ideology, normative alexithymia and fear of intimacy reported more negative attitudes towards seeking professional psychological help. Normative alexithymia accounted for the variance in help seeking previously observed by fear of intimacy during regression modelling. Sexuality and ethnicity also significantly accounted for a proportion of unique variance in men's help seeking attitudes. People who had received previous support from a mental health professional showed more positive attitudes towards seeking psychological help.

Conclusions

Men's attitudes towards seeking psychological help were closely related to traditional masculine ideology and normative alexithymia. A degree of content or construct overlap may exist between normative alexithymia and fear of intimacy in men. Limitations of this study and implications for future research are discussed.

Key words: masculinity, emotion, intimacy, men's help seeking

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Average life expectancy from birth is four years less for men than it is for women, and across the lifespan men are at greater risk from nearly all major illnesses and injury (O'Brien & White, 2003; Courtenay, 2009; Coalition on Men & Boys [COMAB], 2009). Men engage in more health related risky behaviours than women (Courtenay, 2000), they suffer more substance abuse and dependence (Kessler et al. 1994), make up the vast majority of the prison population (Prison Reform Trust, 2005) and those who are homeless (Gill, Meltzer, Hinds & Pettcrew, 1994), and are three times more likely to take their own lives through suicide (NIMHE, 2008).

Men's physical and mental health has traditionally been marginalised, not least by men themselves. In the US there has been an established interest in men's mental health over the last 30 years. In the UK, only recently has men's mental health been a focus of interest, mainly from non-statutory organisations such as the Men's Health Forum (2006a; 2010; 2011), Mind (2009) and the Samaritans (2010). A scoping study on men's health carried out by White (2001) identified men's reluctance to access health care services as a primary issue related to poorer health outcomes for men in the UK.

Attitudinal and behavioural gender differences have been found. In 1970, Fischer and Turner developed the Attitudes Towards Seeking Professional Psychological Help Scale, which produced consistently strong findings that women in the US express more willingness to seek psychological help than men (Fischer & Turner, 1970; Price & McNeill, 1992; Sanchez & Atkinson, 1983). Figures of health care service utilisation in the UK indicate that

men are less likely to voluntarily use mental health care services, including psychological therapies (Glover, Webb & Evison, 2010; ISD, 2000; ONS, 2004, 2010; NHS Information Centre, 2009, 2010; The Scottish Government, 2009). Men's underutilisation of psychological interventions is particularly noticeable at the primary care level. Recent statistics for the Increasing Access to Psychological Therapies (IAPT) programme show a two-to-one ratio of women to men using IAPT services (Glover, et al., 2010).

Good, Dell and Mintz (1989) noted with surprise how little attention had been given in the help seeking literature to male gender roles given they appear to be "intuitively antithetical to the behaviour of help seeking" (Good et al., 1989, p295). Traditional (Pleck, 1981, 1995) and hegemonic (Connell, 1995) masculinity were hypothesized to be the dominant ideology for men in the US. Traditional and hegemonic masculinities propose a common constellation of standards and expectations for male behaviour exists which endorses certain traits, including physical strength, wealth, professional success, power, risk taking, invulnerability, virility, stoic emotionality, control, dominance, excessive competitiveness and anti-femininity. Men are strongly encouraged to aim for theses ideals, which privilege the dominant position of some men (Connell 1995). Many aspects of traditional/hegemonic masculinity have been hypothesised to be in direct conflict with psychological help seeking, which emphasises more 'feminine' traits such as emotional expression, introspection, intimacy, and an acknowledgement of vulnerability (Brooks, 1998; Pollack & Levant, 1998; Rochlen, 2005).

In the US, research into gender role socialisation theories and men's attitudes towards professional psychological help seeking has focused on gender role ideology and gender role

conflict (GRC) (Addis & Mahalik, 2003). Research has primarily adopted correlational designs with undergraduate student samples to examine individual differences in adherence to traditional masculine norms, gender role conflict and men's attitudes towards psychological help seeking (Blazina & Marks, 2001; Blazina & Watkins, 1996; Berger et al. 2005; Good, et al., 1989; Good & Wood, 1995; Lane & Addis, 2005; Mendoza & Cummings, 2001; Simonsen, Blazina & Watkins, 2000; Wisch, Mahalik, Hayes & Nutt, 1995). Men's attitudes towards psychological help seeking have been found to be more closely related to traditional masculine ideology than to gender role conflict (Berger et al., 2005).

Qualitative research in the UK has also linked traditional masculine ideology to UK men's attitudes towards help seeking (Galdas, Cheater & Marshall, 2005; O'Brien, Hunt & Hart, 2005; Ritchie, 1999; White, 2001). O'Brien et al. (2005) carried out 14 focus groups with 55 Scottish men. They found men were reluctant to seek help, particularly for minor problems and mental health difficulties. They concluded that there was "a widespread endorsement of a 'hegemonic' view that men 'should' be reluctant to seek help, particularly amongst younger men" (p. 503). To date no quantitative research in the UK has been conducted to determine if these findings are generalisable to a wider UK population.

Theories of masculine ideology hypothesise that gender role socialisation impacts on men's emotional and interpersonal lives (O'Neil, 1981; Levant, 1990). However, these hypothesised consequences have often been proposed with little account of, or evidence for, the psychological processes though which they develop (Addis & Cohane, 2005). Levant (1990) suggests that selectivity and difficulty identifying emotional states and a fear of

intimacy in men can partially account for their negative attitudes towards psychological therapy.

The restrictive emotionality factor of O'Neil's (1981, 2008) Gender Role Conflict paradigm relates to difficulties in self disclosure, recognising feelings and processing the complexities of interpersonal life (O'Neil, 1981). In a large scale survey of 401 undergraduate students from the US, Good et al. (1989) found restrictive emotionality to be the biggest predictor of men's negative attitudes towards psychological help seeking. Similar to restrictive emotionality is alexithymia, which Levant (1998) hypothesised to be a widespread condition amongst men and refers to the inability to verbalise emotions. Levant et al. (2003) found a relationship between the endorsement of traditional masculinity and higher degrees of alexithymia in men. Contrary to their hypothesis, in a correlational study of 155 men from the US, Berger et al. (2005) did not find alexithymia to be associated with more negative attitudes towards psychological help seeking. The authors propose this may have been due to the specificity of the measure used and the absence of a measure of normative male alexithymia.

Little attention has been given to intimacy as a predictor of men's attitudes towards seeking psychological help. One correlational study of 208 male undergraduate students from the US found greater GRC to be associated with greater levels of alexithymia and fear of intimacy (Fischer & Good, 1997). Fischer & Good (1997) concluded that a fear of intimacy may be an important factor affecting men's ability to form personal connections with a therapist. In the UK, Ritchie (1999) conducted a focus group using vignettes with 18 men aged between 16-35 years-old. Using an interpretative paradigm, Ritchie (1999) found that

the young men in her sample had difficulty accessing confiding relationships with male friends for emotional difficulties. Indeed, men often report having fewer social support networks than women (Boreham, Stafford & Taylor, 2000; Pevalin & Rose, 2003), which may be related to an avoidance of forming close attachments (MHF, 2006a).

Studies have concluded that masculinity influences help seeking behaviour. However, only a few studies have explored variations between different groups of men (Berger et al., 2005; Duncan, 2003; Lane & Addis, 2005; Simonsen, Blazina & Watkins, 2007), often because of an over-reliance on student populations and the homogeneity of many of the samples. Furthermore, there has been little investigation comparing the help seeking attitudes of men who have received previous support from mental health professionals and those who have not.

The Present Study

The main aim of this research is to determine, using a large scale survey design, if adherence to traditional/hegemonic forms of masculinity is associated with UK men's attitudes towards seeking professional psychological help. In addition, the hypothesised emotional and interpersonal implications of male development and gender role socialisation will also be explored as potential factors associated with men's attitudes towards seeking professional psychological help. Variations in help seeking attitudes between different groups of men will be examined along with the impact demographic factors have on predictor variables of interest. Finally, comparisons in help seeking attitudes of people who have or have not received previous support for psychological problems will be explored.

Hypotheses

The present research will examine the following hypotheses:

1. Greater endorsement of traditional masculine norms will be associated with more negative attitudes towards seeking professional psychological help.

2. Greater levels of normative male alexithymia will be associated with more negative attitudes towards seeking professional psychological help.

3. Greater fear of intimacy will be associated with more negative attitudes towards seeking professional psychological help.

4. Masculinity, fear of intimacy and alexithymia will significantly account for the observed variance between men's negative attitudes towards seeking professional psychological help.

5. People who have received support from a mental health professional for psychological difficulties will differ significantly in their attitudes towards seeking professional psychological help compared to those who have not.

Methods

Design

A cross-sectional online survey strategy was used to administer standardised measures that were subject to quantitative analysis. A website, Men's Minds Matter, was developed to host the survey (www.mensmindsmatter.com). The design of the site aimed to be relatively neutral to avoid putting off different groups of men.

Participants

Power calculations were conducted to establish an appropriate sample size in accordance with the research questions. Based on achieving a small effect size as observed in other similar studies (e.g. Fisher & Good, 1997; Berger et al. 2005), with a statistical power of .8 (Cohen, 1988; Field, 2009), and considering the inclusion of up to 20 predictor variables (including demographics) into the planned final regression model, the researcher aimed to recruit a minimum of 210 participants (Green, 1991).

The age breakdown of participants can be seen in Table 1. Of the sample 94 percent were white, two percent mixed ethnicity, two percent Asian or Asian British, two percent black/African/Caribbean/black British. Sixty-four percent reported that they were not religious, 27 percent described their religious beliefs as Christian, two percent Buddhist, two percent Jewish, one percent Hindu, one percent Muslim, three percent other. Regarding marital status, 43 percent were single, 33 percent married/civil partnership, 18 percent cohabiting, three percent divorced, two percent separated, and one percent other. Eighty-six percent described their sexuality as heterosexual and 14 percent identified themselves as gay.

Table 1

Age of participants

Age group	Frequency	Percentage
18-25	97	17
26-35	279	49
36-45	119	21
46-55	50	9
56-65	27	4
Over 65	3	1
Total (Missing)	575 (6)	100

Sixty-five percent of the sample was in fulltime employment, 11 percent self employed, nine percent students, four percent part-time employment, five percent looking for work, two percent retired, one percent house people and three percent other. Regarding income, 25 percent earned between £0-15000, 18 percent between £15001-25000, 26 percent between £25001-35000, 12 percent between £35001-45000, 10 percent between £45001-60000, three percent between £60001-80000 and six percent earned over £80001.

Two percent had no formal qualifications, 10 percent GCSE's/CSE's/O'levels, 23 percent A'levels/AS levels/NVQ/GNVQ/Diploma, 32 percent university degrees, 10 percent professional qualifications and 23 percent postgraduate qualifications. Participants came from a variety of occupations which can be seen in Table 2 below.

Table 2

Participant Occupations

Occupation	Frequency	Percentage
Business executive	12	2
Craftsman / tradesman	23	3
Education	43	8
IT	61	11
Manual / factory	11	2
Media	49	8
Medical services	12	2
Mental health services	14	3
Middle management	33	6
Office / clerical	30	5
Own business	19	4
Professional	62	11
Public services	32	6
Senior management	18	4
Shopworker	17	3
Psychologist/trainee psychologist	36	6
Other	91	16
Total (missing)	564 (17)	100

Thirty-seven percent were private tenants, 29 percent home owners, 14 percent were in joint ownership, 12 percent living with parents, four percent lived in student housing, three percent council tenants and one percent had no fixed address. Nearly half of the sample lived in Greater London and the South East of England (Table 3).

Table 3

Participants UK region of residence

UK region	Frequency	Percentage
Scotland	24	4
Northern Ireland	7	1
Wales	17	3
East Midlands	41	7
East of England	19	3
Greater London	154	27
North East England	28	5
North West England	58	10
South East England	125	22
South West England	38	7
West Midlands	39	5
Yorkshire and the Humber	33	6
Total (Missing)	572 (9)	100

Measures

Demographic information. A demographic questionnaire made up the first page of the survey and gathered information about participant age, gender, ethnicity, religion, marital status, educational achievements, employment status, occupation, residential status, income, UK residency, UK region, nationality and sexuality. Participants were also asked how they had found the site and if they had previously received support from their GP or a mental health professional for a psychological difficulty.

Fear of Intimacy Scale (FIS; Descutner & Thelen, 1991). The FIS consists of one single 35-item-factor and was designed to assess individuals' anxieties about close relationships. Participants are instructed to complete the questionnaire while imagining themselves in a close dating relationship. Respondents rate how characteristic each statement is of them on a 5-point scale (1 = "not at all characteristic of me," 5 = "extremely characteristic of me"), with higher scores indicating greater fear of intimacy. Fifteen items are reverse scored and all items are summed to obtain a total score. Descutner and Thelen (1991) reported a one-month test-retest correlation of .89 and good internal consistency (α = .92). FIS scores have been found to correlate with respondents self-report, therapist ratings, loneliness, comfort with closeness and self disclosure (Descutner & Thelen, 1991; Doi & Thelen, 1993).

Normative Male Alexithymia Scale (NMAS; Levant et al., 2006). The NMAS consists of one single 20-item-factor. Participants are asked to respond to questions about their experience of emotions using a 7-point Likert scale (1 [strongly disagree] to 7 [strongly agree]). Seven items are reverse scored with the total scale score calculated from the average. Higher scores are indicative of greater normative male alexithymia. Scores on the NMAS show very good internal consistency (α = .92-.93) and test retest reliability (r = .86-.91) over a 1-2 month period. Results of analyses of gender differences, relations of NMAS with other instruments, and its incremental validity in predicting masculine ideology, provide evidence to support the validity of the scale (Levant et. al., 2006).

Male Role Attitudes Scale (MRAS; Pleck et al., 1994). The MRAS is a single seven-item-factor of the endorsement of traditional masculine ideology. Participants are asked to

indicate the extent of their agreement or disagreement on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Higher scores are indicative of a greater endorsement of traditional masculine ideology. The MRAS was found to have a coefficient alpha of .56 (Pleck et al., 1994) and .67 (Levant, Rankin, Williams, Hasan & Smalley, 2010). More traditional attitudes toward masculinity were correlated with coercive sexual behaviour, the perception of heterosexual relationships as adversarial, the belief that making women pregnant validates masculinity, and general delinquency and alcohol/drug use (Pleck et al., 1994). Convergent validity is provided through significant correlations with the Masculine Role Norms Inventory – Revised (Levant et al., 2010).

Attitudes Towards Seeking Professional Psychological Help Scale – Short Form (ATSPPH-SF; Fischer & Farina, 1995): The scale was developed to explore attitudes towards seeking professional psychological help. The scale consists of 10 items loaded on one single factor. Five items are reverse scored. According to Fischer and Turner (1995) the ATSPPH-SF has good internal consistency (α = .86) and its test-retest reliability is acceptable too (r = .73 - .89). According to Good and Wood (1995), the measure has demonstrated construct validity because it has consistently discriminated between college students who have sought professional psychological assistance and those who had not.

Procedure

The website was piloted with male clinical psychology trainees and a small group of men from the general population. Overall, the feedback was positive and people felt that the site concept would encourage people to take part in the research. One trainee felt that the design was "not manly enough" whilst another male from the general population reported

that the design "felt informal and less threatening than an official site associated with the NHS". Based on feedback some small changes were made to the site. For example, a ghost bar for Likert scale response categories was incorporated into the website so that option choices were always in view as the participant scrolled down the page.

Ethical approval to carry out the project was given by the Social and Applied Sciences Ethics panel at Canterbury Christ Church University. Information about the research was provided on the website and all participants completed a consent form before taking part. Survey data was held in a password protected database which was only accessible to the lead researcher. As an incentive participants who completed the survey could enter into a free prize draw to win an iPod Nano. Participant's emails for the free prize draw were stored separately with no identifying information. Participants were able opt in to receive a short report on the findings by leaving their email address. The Ethics panel at Canterbury Christ Church University also received a copy of the report.

Sampling Strategies

A Facebook page was developed using the website name Men's Minds Matter. Information about the research was provided as per the main website. Invitations were sent to join the page and requests were made for people and organisations to post links on their own Facebook pages should they choose to do so.

A Twitter page was set up using the website name from the main site. During the data collection period specific Tweets about the research were made with some facts and figures on men's mental health. As more people became followers of Men's Minds Matter the ability

to reach a wider audience became significantly greater. Tweeters, celebrities and organisations including, the Men's Health Forum and Mind tweeted about the research.

Several online forums were approached and requests made to post information about the research with associated links. Forums which agreed to posting links included the East Dulwich Forum, Manchester Forum, Glasgow Forum and Age Concern. In addition, The Samaritans, Men's Health Forum and Mind posted information about the research on their websites. One thousand postcards and business cards were handed out in Royal Tunbridge Wells, London Bridge and Peckham. Finally, course directors from clinical psychology programmes were approached for permission to distribute a letter to trainees and staff requesting them to take part in the research.

Data Collection

Data collection started on the 7th September 2010 and finished on the 15th January 2011. Google analytics was used to monitor traffic through the site. In total there were 1482 unique visitors to the site with 38 percent of visitors only viewing a single-page before leaving. In total, 1270 unique visitors were from the UK with the remaining visits coming from other countries. There were a total of 751 people from the London area who visited the site with the remainder of visits coming from regions outside of London. Of these 1270 unique visitors, 883 started the survey and consented to take part in the research. Two hundred and nine people dropped out before completing the demographics page. Further attrition rates are shown in Table 4 below.

Table 4

Attrition rates per internet survey page

Measure	Survey page	No of participants	Attrition	Percentage
Demographics	Survey p1	674	45	7
MRAS	Survey p2	626	26	4
NMAS	Survey p3	600	33	5
	Survey p4	567	16	2
ATSPPH-SF	Survey p5	551	17	3
FIS	Survey p6	534	19	3
	Survey p7	515	11	2
	Survey p8	504	1	1
	Total	NA	167	27

Thirty-five percent of the people who took part in the survey reported finding the research through the social networking site Twitter, 32 percent found the site following a friends recommendation, nine percent via the sites accompanying Facebook page, eight percent via email, eight percent via a link from another site, three percent from another social networking site, one percent from an internet blog, one percent from an online search, one percent from a magazine and two percent from other sources.

Data cleansing and exclusion of outliers.

Twelve cases were excluded due to technical errors in data recording that were linked to participants returning to previous web-pages using the 'back' function on their browser. Twenty-four people were excluded from the analysis because they did not live in the UK and a further 26 people were excluded because they were identified as female.

MRAS in non UK responders (Mdn = 18) differed significantly from MRAS scores of UK responders (Mdn = 17), U = 4790.5, Z = -2.386, P < .05, r = -.1. NMAS in females (Mdn

= 3.15) was found to differ significantly to males (Mdn = 3.77), U = 2835.5, Z = -1.766, P < .05, r = -.08) as did ATSPPH-SF scores (females, Mdn = 22) (males; Mdn = 18), U = 2323.5, Z = -2.166, P < .05, r = -.1. No other significant differences were observed.

The difference between forward and reversed scores was calculated for each individual on measures that used reverse coding (NMAS, FIS, ATSPPH-SF). Extreme scores were identified using descriptive statistics, boxplots and histograms. The data for individuals whose scores indicated that they may be outliers were scanned. Thirty-one people were excluded from further analysis. In total, 581 people formed the final dataset and 434 were included in the final regression model.

Non-completers.

Non-completers were classified as individuals who dropped out prior to completing all the five measures. Non-completers were found to differ significantly in relationship status (α^2 = 3.998, df =1; p = .05), occupation (α^2 = 30.61, df = 16; p = .05), and ethnicity (α^2 = 17.31, df =6; p = .01). More specifically, individuals who were not in a relationship were less likely to complete the survey than those individuals in a relationship. People from Asian/Asian British or Black/ African / Caribbean / Black British backgrounds were less likely to complete the survey. People who worked as business executives, craftsmen/tradesmen, medical services and shop workers were less likely to complete the survey than those from other professions.

Data Analysis

Biserial and point-biserial correlations were carried out between demographic, predictor and dependent variables to explore relationships and test for the potential confounders, including age, ethnicity, marital status, educational achievement, residential status, occupation, employment status and sexuality. Relationships between the dependent and predictor variables were tested using the bivariate Pearson's correlations.

Boxplots and P-P plots were used to visually check the distribution of predictor and dependent variables for skewness and kurtosis. Associated quantified analysis and z-scores were calculated. However, Field (2009) highlights that because small deviations can yield significant findings within large samples (>200) it is important to look at the values of skew and kurtosis, rather than calculate significance using z-score standard deviations. Some negative skew was observed for the ATSPPH-SF and some negative kurtosis on the distribution of the NMAS and FIS scales. Given the large sample size the distribution of data for each measure was considered to be within the parameters for normal distributions.

Regarding regression analysis, no substantial correlations (r > .9) were found between predictor variables. Tolerance statistics and VIF values also suggested that collinearity was not a problem for the regression models. The Durbin-Watson value of 1.95 indicated that the assumption of independent errors was met. Casewise diagnostic revealed 18 cases to have standardised residuals within ±2 which indicated that the data represented a fairly accurate model. No cases were considered to have undue leverage (Hoaglin & Welsch, 1978), whilst Mahalanobis distances were within acceptable limits (Barnett and Lewis, 1978). DFBeta statistics were within the limit of ±1. Four cases were below CVR parameters although

Cook's distance for these cases suggested no cause for alarm. Assumptions of linearity and heteroscedasticity were met and residuals appeared normally distributed.

Some degree of covariance was observed between the NMAS and FIS (r = .77, < .001 [one-tailed]). When entered into the regression model together, NMAS accounted for the variance previously observed in FIS. A decision was made to explore the combined effect of NMAS and FIS on ATSPPH-SF by converting scale scores into z-scores and using the average as a measure of their combined effect. Both average and difference z-scores were used in the final regression modelling. For the purpose of regression modelling the demographic variables age (under 25 and over 26), ethnicity (British/other), religious beliefs (no/yes), relationship status (no/yes), education (GCSE or below/A'levels and above), income (under £25K/over 25K) and employment status (no/yes) were dichotomised.

The relationship between previous support from a health professional and ATSPPH-SF was investigated using the t-test. Further exploratory analysis was carried out to investigate demographic characteristics of people who had previously received support from a mental health professional. Interpretation of these finding should be considered with some caution as they were not determined a-priori and could yield Type I errors.

Results

Mean score for the predictor variables MRAS, NMAS, FIS and the outcome variable ATSPPH-SF can be seen below in Table 5.

Table 5

Mean scores for predictor and dependent variables

Measure	N	Mean	Std Deviation
MRAS	539	16.7	3.1
NMAS	488	3.7	1.1
FIS	434	85.5	24.9
ATSPPH-SF	476	17.6	6.0

Correlational Analysis

Relationship between demographic and predictor variables.

Biserial and point bi-serial correlations were carried out to identify potential confounders and describe relationships between the measures used in the study and demographic variables age, ethnicity (white British/all other groups), religion (not religious/religious), relationship status (in a relationship/single), education, employment status (no/yes), income, and sexuality (heterosexual/gay).

MRAS.

Increasing age ($rs = -.137$, $p < .01$ [one-tailed]), income ($rs = -.088$, $p < .05$ [two-tailed]) and educational achievement ($rs = -.127$, $p < .01$ [two-tailed]) were negatively correlated with MRAS. People from other ethnic groups ($rpb = .86$, $p < .05$ [two-tailed]) and

those with religious beliefs (rpb = -.137, p < .01 [two-tailed]) reported higher levels of MRAS.

NMAS.

Educational achievement (rs = -.115, p < .05 [two-tailed]) was negatively correlated with NMAS. People who were religious reported lower levels of NMAS (rpb = -.112, p < .05 [two-tailed]) whilst those who were not in relationships reported higher NMAS (rpb = .121, p < .01 [two-tailed]).

FIS.

Increased income (rs = -.122, p < .05 [two-tailed]) and educational achievement (rs = -.163, p < .01 [two-tailed]) were negatively correlated with FIS. People who were single (rpb = .325, p < .001 [two-tailed]) or gay (rpb = .116, p < .05 [two-tailed]) reported higher levels of FIS.

ATSPPH-SF.

A significant correlation was observed between ATSPPH-SF and age (rs = .096, p < .05 [one-tailed]), ethnicity (rpb = .120, p < .01 [one-tailed]) and sexuality (rpb = -.120, p < .05 [two-tailed]). More specifically, as age increased men's ATSPPH-SF became more positive. Individuals from other ethnic groups and those who identified themselves as gay showed more positive ATSPPH-SF. Mean ATSPPH-SF scores for demographic variables are provided in Table 6.

Table 6

Mean ATSPPH-SF scale scores for demographic variables

Variable		N	ATSPPH-SF Mean	Std deviation
Age	18-25	76	16.5	5.8
	26-35	231	17.4	5.6
	36-45	98	18.6	6.9
	46-55	43	18	6
	Over 56	24	18.2	6.6
Ethnicity	White British	409	17.3	6
	Other	64	19.5	5.6
Sexuality	Heterosexual	391	17.2	6.1
	Gay	56	19.4	4.9

Relationships between predictor and dependent variables.

Hypothesis 1: Traditional masculine norms and ATSPPH-SF

Bivariate Pearson's correlation was conducted for the predictor variable MRAS and ATSPPH-SF (see table 7). MRAS was found to be negatively correlated with ATSPPH-SF ($r = -.27$, $p < .001$ [one-tailed]). Psychologically this means that as men's endorsement of traditional masculine ideology increased, their attitudes towards seeking psychological help became more negative. The coefficient of determination (R^2) indicated that the MRAS accounted for seven percent of the variance observed in ATSPPH-SF.

Hypothesis 2: Normative male alexithymia and ATSPPH-SF.

Bivariate Pearson's correlation was carried out between NMAS and ATSPPH-SF. NMAS was found to be negatively correlated with ATSPPH-SF ($r = -.29$, $p < .001$ [one-

tailed]). More specifically this means that as levels of alexithymia increased men's attitudes toward seeking professional psychological help became more negative. The coefficient of determination (R^2) was calculated and NMAS accounted for eight percent of variance observed in ATSPPH-SF.

Hypothesis 3: Fear of intimacy and ATSPPH.

Bivariate Pearson's correlation was carried out between FIS and ATSPPH-SF (r = -.22, p < 0.001 [one-tailed]). Psychologically this means that a greater fear of intimacy in close relationships is associated with more negative attitudes towards psychological help seeking. R^2 indicated that FIS accounted for five percent of the variance observed in ATSPPH-SF.

Table 7

Matrix of Pearson's Correlations with between MRAS, NMAS, FIS and ATSPPH-SF

Variables	MRAS	NMAS	FIS	ATSPPH-SF
MRAS	1	.336**	.202**	-.267**
NMAS		1	.772**	-.293**
FIS			1	-.218**
ATSPPH-SF				1

Notes: ** p > 0.001

Regression Analysis

Hypothesis 4: Masculinity, fear of intimacy, alexithymia and ATSPPH-SF

Given the covariance between NMAS and FIS both predictors were entered into regression models separately with MRAS as predictors of ATSPPH-SF.

MRAS and NMAS as predictors of ATSPPH-SF.

In the first stage of the regression analysis ATSPPH-SF was the dependent variable with MRAS and NMAS the predictor variables of interest (Table 8).

Table 8

MRAS and NMAS as predictors of men's ATSPPH-SF

Model	B	SE B	β	t	p
Constant	28.34	1.48		19.133	.001
MRAS	-0.37	0.09	-.190	-4.2	.001
NMAS	-1.22	0.24	-.230	-5.05	.001
Notes: R^2 = .12 (p > .001)					

MRAS and NMAS were shown to be predictive of ATSPPH-SF. R^2 demonstrated that MRAS and NMAS accounted for 12 percent of the variance observed in ATSPPH-SF. The adjusted R^2 (.12) was the same as the value of R^2 which indicated the cross-validity of the model to be very good.

MRAS and FIS as predictors of ATSPPH-SF.

In the second stage of the regression analysis MRAS and FIS were entered as the predictor variables, with ATSPPH-SF the dependent variable. MRAS and FIS were predictive of men's ATSPPH-SF. R^2 showed that MRAS and FIS accounted for 10 percent of the variance observed in ATSPPH-SF. The adjusted R^2 (.10) indicated that the model generalises to similar men from the UK general population. A summary of the model can be found in Table 9.

Table 9					
MRAS and FIS as predictors of men's ATSPPH-SF					
Model	B	SE B	β	t	p
Constant	28.981	1.646		17.607	.000
MRAS	-.477	.092	-.242	-5.196	.000
FIS	-.040	.011	-.169	-3.640	.000
Notes: R^2 = .10 (p > .001)					

MRAS, NMAS and FIS as predictors of ATSPPH-SF.

In the third stage of the regression analysis MRAS, NMAS and FIS were entered as predictor variables with ATSPPH-SF as the dependent variable. Overall, the model accounted for 13 percent of the variance observed in ATSPPH-SF. However, FIS was no longer significant with the variance previously observed being accounted for by NMAS (Table 10).

Table 10

MRAS, NMAS and FIS as predictors of ATSPPH-SF

Model	B	SE B	β	t	p
Constant	28.785	1.630		17.662	.000
MRAS	-.405	.094	-.206	-4.336	.000
NMAS	-1.220	.381	-.234	-3.201	.001
FIS	.001	.017	.004	.054	.957
Notes: R² = .13 (p > .001)					

MRAS and combined NMAS and FIS as predictors of ATSPPH-SF.

Given that NMAS and FIS were highly correlated both factors were combined by converting each scale into z-scores. Two new variables were created; the average of the combined z-scores and the difference between the combined z-scores. These scores were used to calculate a combined effect of NMAS and FIS in further regression analysis (see Table 11).

Table 11

MRAS, z-score average and z-score difference as predictors of ATSPPH-SF

Model	B	SE B	β	t	p
Constant	24.33	1.574		15.453	.000
MRAS	-.405	.094	-.206	-4.336	.000
z-score average	-1.368	.296	-.217	-4.618	.000
z-score difference	-.707	.402	-.080	-1.757	.080

Notes: R^2 = .13 (p > .001)

The model accounted for 13 percent of the variance observed in ATSPPH-SF. More specifically this means average z-scores for both FIS and NMAS accounted for slightly more variance in ATSPPH-SF than either measure alone. Both the R^2 and adjusted R^2 (.12) were very close which meant that the model could generalise to similar men from within the UK general population.

Final regression model.

The final stage of the regression analysis included social and psychological variables in step one followed by predictor variables in step two to determine the unique variance of predictor variables when demographic factors were included (see Table 12).

Table 12

Regression model for MRAS, z-score average and z-score difference as predictors of ATSPPH-SF whilst controlling for demographic variables

Model	B	SE B	β	t	p
Step 1					
(Constant)	13.158	1.580		8.329	.000
Age	1.518	1.022	.095	1.485	.138
Ethnicity	1.762	.916	.105	1.923	.055
Religion	.399	.675	.032	.590	.555
Relationship status	-.095	.704	-.008	-.134	.893
Education	.328	1.030	.018	.319	.750
Income	.309	.745	.025	.414	.679
Sexuality	2.196	.954	.126	2.301	*.022
Employment status	1.021	1.131	.055	.903	.367
Step 2					
(Constant)	20.403	2.404		8.487	.000
Age Binary	1.178	.969	.074	1.216	.225
Ethnicity	1.864	.872	.111	2.136	*.033
Religion	.480	.653	.038	.734	.463
Relationship status	.170	.715	.014	.238	.812
Education	.760	.975	.041	.780	.436
Income	-.087	.704	-.007	-.124	.902
Sexuality	2.020	.907	.116	2.227	*.027
Employment status	1.004	1.066	.054	.941	.347
MRAS total score	-.405	.107	-.211	-3.804	**.000
Zscore_average	-1.358	.352	-.213	-3.855	**.000
Zscore_difference	-.472	.491	-.053	-.961	.337

Notes: $R^2 = .04$ (p > .01) for step 1; ^ $R^2 = .16$ for step 2 (p > .001)

In the first regression analysis sexuality was found to significantly account for two percent of the observed variance with ATSPPH-SF. Overall, the demographic variables included in step one of the regression model significantly accounted for four percent of the variance observed in ATSPPH-SF (adjusted R², .02). In step two of the regression both sexuality and ethnicity significantly accounted for three percent of the unique variance observed in ATSPPH-SF. MRAS significantly accounted for four percent, whilst the z-score average of NMAS and FIS significantly accounted for an additional four percent of the unique variance observed in ATSPPH-SF. In step two the overall model significantly accounted for 16 percent of the variance observed in ATSPPH-SF (adjusted R², .13). The model is generalisable to similar men from within the UK general population

Hypothesis 5: Previous support and ATSPPH-SF

Respondents were asked if they had ever received support from their GP or a mental health profession for their psychological health. Everybody who completed the survey reported having received support from their GP and no further analysis was carried out. Thirty-five percent of respondents reported having received support from a mental health professional for a psychological health problem.

The hypothesis was tested that there would be a difference in ATSPPH-SF between those who had received previous support from a mental health professional and those who had not. An independent t-test was carried out which indicated that individuals who had received support from a mental health professional had significantly more positive ATSPPH-SF ($t(473) = -9.51$, $p > .001$; Table 13).

Table 13

Mean score of people who had and had not received previous support from a mental health professional

Previous support	N	Mean	Std Deviation
Yes	165	20.87	5.31
No	310	15.84	5.58

Further exploratory analysis was carried out to determine if those who had received support from a mental health professional differed on the predictor variables MRAS, NMAS and FIS (Table 14). No significant difference was found between people who had received help from a mental health professional on MRAS and NMAS. However, those who reported having not received previous support from a mental health professional also reported a significantly greater fear of intimacy (t (431) = -2.517, p > .05; two-tailed).

Table 14

Mean score comparisons between previous support from a mental health professional on predictor variables

Measure	Previous Support	N	Mean	Std Deviation
MRAS	Yes	352	16.82	3.08
	No	186	16.45	3.18
NMAS	Yes	319	3.67	1.09
	No	168	3.81	1.22
FIS	Yes	289	83.33	23.74
	No	144	89.92	26.62

In addition to exploring differences on mean scores for predictor and outcome variables differences were explored on demographic variables associated with ATSPPH-SF. A significant difference was observed on the demographic variable age ($\alpha^2 = 19.9$, df =4; p = .01; Table 15).

Table 15

Percentage of people who had or had not received support from a mental health professional across age groups

Previous support		Age					
		18-25	26-35	36-45	46-55	Over-56	Total
No	N	67	200	61	26	21	375
	percent	62%	72%	51%	53%	72%	65%
Yes	N	30	79	58	23	8	198
	percent	38%	28%	49%	47%	28%	35%

Discussion

As hypothesised, men who endorse more traditional masculine ideology also report more negative attitudes towards seeking professional psychological help. The results support previous qualitative research in the UK that indicates traditional masculinity is an important factor influencing UK men's attitudes towards psychological help seeking (Galdas, Cheater & Marshall, 2005; O'Brien, Hunt & Hart, 2005; Ritchie, 1999; White, 2001). The findings are also supportive of findings from large scale surveys from the US (Berger et al. 2005; Blazina & Marks, 2001; Blazina & Watkins, 1996; Good, et al., 1989; Good & Wood, 1995; Lane & Addis, 2005; Mendoza & Cummings, 2001; Simonsen, Blazina & Watkins, 2000; Wisch, Mahalik, Hayes & Nutt, 1995).

Alexithymia was also found to be significantly associated with UK men's attitudes towards seeking professional psychological help. These findings are different to those of Berger et al. (2005) who did not find alexithymia to be associated with men's help seeking attitudes. As proposed by Berger et al. (2005) the significant findings in this study are likely to be due to the measure of normative alexithymia used, as opposed to a measure of clinical alexithymia.

A greater fear of intimacy was found to be significantly associated with more negative attitudes towards seeking professional psychological help. However, when all three predictor variables were placed into the regression model, fear of intimacy no longer remained significant. This was because the variance in help seeking previously observed by fear of intimacy was accounted for by normative alexithymia. Both intimacy and alexithymia were more highly correlated than expected from previous studies (Fischer & Good, 1997) and may

represent a degree of content or construct overlap. The hypothesis that masculinity, fear of intimacy and alexithymia would significantly account for the observed variance in men's negative attitudes towards seeking professional psychological help was only partially supported.

The decision to combine normative alexithymia and fear of intimacy into one factor enabled their combined effect on men's attitudes toward psychological help seeking to be explored. After accounting for demographic variables masculinity still accounted for four percent of the unique variance in men's help seeking attitudes and the combined effect of normative alexithymia and fear of intimacy a further four percent. Sexuality accounted for two percent of the unique variance in men's attitudes towards psychological help seeking and ethnicity accounted for one percent of unique variance. Although age was found to be associated with masculinity and men's attitudes towards psychological help seeking it did not significantly account for any unique variance in the final model. Overall, white British, heterosexual males and those who reported higher levels of adherence with traditional masculine norms, greater alexithymia and a greater fear of intimacy reported more negative attitudes towards seeking professional psychological help.

The final regression model significantly accounted for 16 percent of the variance observed in men's attitudes towards psychological help seeking, with an adjusted R^2 of .13. Therefore, the regression model appears to be accurate for the sample and may be generalisable to similar men from the wider UK population. Although only small effect sizes were observed, these are similar to effect sizes in similar large scale survey studies from the US. Furthermore, small effect sizes are not uncommon in social psychological research

(Richard, Bond & Stokes-Zoota, 2003). Whilst there may be other important variables associated with help seeking in both genders, these factors are theoretically specific to the male experience and therefore important in accounting for men's attitudes toward seeking professional psychological help.

Those who had received help from a mental health professional for a psychological problem showed significantly more positive attitudes towards seeking professional psychological help. However, we are unable to conclude why this is the case and we do not know whether those who sought help always had more positive attitudes, if their attitudes changed after receiving support or a combination of both.

Theoretical implications

Research into masculine gender ideology has been criticised for its restrictive assumptions regarding the concept (Bergman, 1995; Galdas et al., 2005). More recent theoretical literature acknowledges that multiple masculinities exist and change over time and place (Kimmel, 1994, 2000; Pattman et al., 2005). Research into more marginalised masculinities and how different groups of men relate to help seeking would add richness to the psychology of men and masculinity.

In this study alexithymia and fear of intimacy were highly correlated, which may represent content or construct overlap. Both of these factors are theoretical consequences of male gender role socialisation. However, there is little evidence for the development processes through which they emerge. Both intimacy and alexithymia may even be sub-factors of a broader construct that represents the developmental consequences of the male gender role socialisation process. For example, emotional expression may relate to an internal

self-schema that is based in independence and an avoidance of affiliation and intimacy with others. Given the strength of the correlation between both of these constructs their relationship to one another needs to be explored and understood in more depth.

Clinical Implications

In 2006, the Equality Act created the 'Gender Duty' which, since April 2007, requires NHS organisations to address health inequalities and understand the impact of their work on men and women as distinct groups (MHF, 2006b, 2008). Clinical psychologists need to become more aware of the male experience and how male development and gender role socialisation impacts on men's help seeking behaviour. This is particularly important within the primary care setting and the IAPT programme where there is a two-to-one ratio of women to men using IAPT services (Glover, et al., 2010).

Clinical psychologists may need to think about how they reach out to men who are in need of support but are reluctant to seek help. Such initiatives will need to incorporate a psychological understanding of men and masculinity and specific groups of men may need to be encouraged to seek help in different ways. Improving men's motivation to seek help early on in the development of a mental health problem is of importance given they are less likely seek help and support for less severe problems (O'Brien et al., 2005)

Traditional psychological interventions may not be welcoming to men who experience difficulties communicating their emotions or fear intimacy with others. Indeed, these factors may need to be considered in more depth to fully understand how to motivate men to seek help and how to engage them when they do attend. For example, Robertson and Fitzgerald (1992) found that traditional men responded more favourably to goal-directed,

problem-focused therapies than emotion-focused exploratory interventions. However, there is currently little empirical evidence that supports the effectiveness of interventions that are specific to men and tackle men's reluctance to seek help (McKelley & Rochlen, 2005).

Limitations

The study had several limitations. First of all self-report measures are susceptible to sources of error such as social desirability, lying and fatigue. Whilst attempts were made to exclude extreme cases, a measure of social desirability may have helped to identify cases that introduced bias into the study. The measure of traditional masculinity ideology used here is based on dominant ideology within western cultures and can tell us very little about other marginalised masculinities and how these may impact on men's help seeking attitudes. The measures of alexithymia and fear of intimacy are also limited given they may be measuring a shared construct.

Systematic differences between those who started the survey and dropped out and those who completed the survey were found to exist. This may affect the representativeness of the sample to the wider population given that those who were single, Asian/Asian British, Black/African/Caribbean/Black British or from certain occupations were less likely to complete the survey. Furthermore, a considerable proportion of people visited the site without taking part. We might hypothesise that these people also differed from those who decided to participate. Furthermore, compared to the general population a larger proportion of the studies sample reported having received support from a mental health professional for a psychological problem (Bebbington, 2000). Therefore, the results presented here may be an over-estimation or under-estimation of the true relationship between predictor and outcome

variables. Whilst attempts were made to sample men from different populations these sampling strategies were ineffective and no participants reported that they had found the site because of the postcard/business card campaign. The social networking site Twitter was the main source through which people were directed towards the site. Twitter may represent a restricted demographic.

A consideration when interpreting the results relates to the social practice of masculinity and how this changes over time, place and context. The research was an online survey and it is likely that people would have completed the survey on their own. Participants may have felt less pressured to adhere to masculine ideology and more able to challenge conventional notions of masculinity (Pattman et al., 2005; O'Brien et al., 2005).

Future research

Future research needs to focus on how to improve men's motivation to seek help and how to engage them in more preventative/maintenance health care behaviours. Help seeking needs to become normal, acceptable and received in a way that preserves, rather than threatens a sense of manliness. Research into groups of men who have been able to overcome barriers to help seeking may help to inform ways to help other men seek help more easily. Initiatives which help to challenge unhelpful masculine scripts and provide alternatives that fit with masculine ideology may be of interest to future researchers. For example, some authors have suggested that language is an important factor affecting men's engagement with help seeking (Conrad & White, 2010). Initiatives that have attempted to reach out to men by packaging intervention differently have been effective in engaging men (Archer et al., 2009).

Whilst alexithymia and fear of intimacy have been hypothesised to exist in adult men, little is known beyond theory about the processes though which these difficulties emerge. More research is needed to incorporate a developmental understanding into the psychology of men and masculinity. Further research would benefit from exploring how masculinity is constructed within specific groups of men including those from different cultures and sexual orientations. The impact of masculinity, alexithymia and intimacy on the therapeutic process would be of interest. For example, it would be interesting to examine how intimacy impacts on men's ability to form relationships with a therapist.

Conclusion

Individual predictor variables significantly accounted for a proportion of the variance observed in UK men's attitudes towards seeking professional psychological help. Regression analysis showed that men's attitudes towards seeking psychological help were most closely related to traditional masculine ideology and normative alexithymia. Sexuality and ethnicity were also predictive of UK men's attitudes towards seeking psychological help. A degree of content or construct overlap may exist between normative alexithymia and fear of intimacy in men and may be important to consider in future research. Researchers and clinicians should aim to explore more marginalised masculinities and increase men's motivation to engage with psychological therapies and other mental health services. Developmental models need to be incorporated into a psychology of men and masculinity.

References

Addis, M.E., & Cohane, G.H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men's mental health. Journal of Clinical Psychology, 61, 633-647.

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. American Psychologist, 58, 5-14.

Archer, M., Brown, J.L.S., Idusohan, H., Coventry, S., Manoharan, A., & Espie, C.A. (2009). The development and evaluation of a large-scale self-referral CBT-I intervention for men who have insomnia: An exploratory study. Behavioural and Cognitive Psychotherapy, 37, 239-248.

Bebbington, P. (2000). The need for psychiatric treatment in the general population. In G. Andrews & S. Henderson (Eds.), Unmet need in psychiatry (pp. 85-96). Cambridge: Cambridge University Press.

Berger, J.M., Levant, R.F., McMillan, K.K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculine ideology, alexithymia, and age on men's attitudes towards psychological help seeking. Psychology of Men and Masculinity, 6, 73-78.

Bergman, S.J. (1995). Men's psychological development: a relational perspective. In R. Levant & W. Pollack (Eds.), A new psychology of men (pp 68-90). New York: Basic Books.

Blazina, C., & Marks, L.J. (2001). College men's affective reactions to individual therapy, psychoeducational workshops, and men's support group brochures: The influence of gender-role conflict and power dynamic upon help-seeking attitudes. Psychotherapy, 38, 297-305.

Blazina, C., & Watkins, C.E., Jr. (1996). Masculine gender role conflict: Effects on college men's psychological well being, chemical substance usage, and attitudes towards help seeking. Journal of Counseling Psychology, 43, 461-465.

Boreham, R., Stafford, M., & Taylor, R. (2000). Health survey for England: Social capital and health. London: The Stationary Office.

Brooks, G. (1998). A new psychotherapy for traditional men. San Francisco: Jossey-Bass.

Brown, J., Cochrane, R., & Cardone, D. (1999). Large-scale health promotion stress workshops: Promotion, programme content and client response. Journal of Mental Health, 8(4), 391-402.

Coalition of Men and Boys. (2009). Men masculinities and equality in public health. London: Coalition of Men and Boys.

Cohen , J. (1988). Statistical power analysis for the behavioural sciences (2nd ed.). New York: Academic Press.

Connell, R.W. (1995). Masculinities. Cambridge: Polity Press.

Conrad, D., & White, A. (Eds.). (2010). *Promoting men's mental health*. Oxford: Radcliffe Publishing.

Courtenay, W.H. (2000). Behavioural factors associated with disease, injury, and death among men: Evidence and implications for prevention. *Journal of Men's Studies,* 9(1), 81-142.

Courtenay, W.H. (2009). Theorizing masculinity and men's health. In A. Broom & P. Tovey (Eds.), *Men's health: Body*, identity and social context (pp. 9-32). London, UK: Wiley-Blackwell.

Department of Health. (2002). National suicide prevention strategy for England. London: Department of Health.

Descutner, C.J., & Thelen, M.H. (1991). Development and validation of a fear-of-intimacy scale. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3(2), 218-225.

Diamond, M.J. (2004). The shaping of masculinity: Revisioning boys turning away from their mothers to construct male gender identity. International Journal of Psychoanalysis, 85, 359-380.

Doi, S.C., & Thelen, M.H. (1993). The fear-of-intimacy scale: Replication and extension. Psychological Assessment, 5(3), 377-383.

Duncan, L. (2003). Black male college students' attitudes toward seeking psychological help. Journal of Black Psychology, 29, 68-86.

Field, A. (2009). Discovering statistics using SPSS (3rd ed.). London: Sage.

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. Journal of College Student Development, 35, 79-90.

Fischer, A.R., & Good, G.E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. Psychotherapy, 34, 160-169.

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. Journal of Consulting and Clinical Psychology, 35, 79–90.

Galdas, P.M., Cheater, F., & Marshall, P. (2005). Men and health help seeking behaviour: Literature review. Journal of Advanced Nursing, 49, 616-623.

Gill, B., Meltzer, H., Hinds, K., & Petticrew, M. (1996). OPCS survey of psychiatric morbidity in Great Britain, Report 7: Psychiatric morbidity among homeless people. London: OPCS.

Glover, G., Webb, M., & Evison, F. (2010). Improving access to psychological therapies: A review of progress made by sites in the first roll-out year. Stockton on Tees: North East Public Health Observatory.

Good, G.E., Dell, D.M., & Mintz, L.B. (1989). Male gender role conflict: Relations to help seeking in men. Journal of Counseling Psychology, 36, 295-300.

Good, G.E., & Wood, P.K. (1995). Male gender role conflict, depression, and help seeking: do college men face double jeopardy? Journal of Counselling and Development, 74, 70-75.

Green, S.B. (1991). How many subjects does it take to do a regression analysis? Multivariate Behavioural Research, 26, 499-510.

ISD. (2000). Consultation rates per 1000 population. Scottish health statistics, section L1. Scotland: ISD.

Kessler, R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, J.A., Walters, E.E., . . . Zaslavsky, A.M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. The New England Journal of Medicine, 352, 2515-2523.

Kimmel, M. (1994). Masculinity as homophobia: Fear, shame and silence in the construction of gender identity. In H.Brod & M.Kaufman (Eds.), Theorizing masculinities (pp. 119-141). California: Sage.

Kimmel, M.S. (2000). The gendered society. Oxford: Oxford University Press.

Kraemer, S. (2000). The fragile male. British Medical Journal, 321(7276), 1609-1612

Lane, J. M., & Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. Psychology of Men & Masculinity, 6, 155–168.

Lax, R.F. (1997). Boys' envy of mother and the consequences of narcissistic mortification. The Psychoanalytic Study of the Child, 52, 118-139.

Levant, R. (1990). Psychological services designed for men: A psychoeducational approach. Psychotherapy, 27, 309-315.

Levant, R. (1998). Deperately seeking language: Understanding, assessing, and treating normative male alexithymia. In W. Pollack & R. Levant (Eds.), New psychotherapy for men (pp. 35-56). New York: Wiley.

Levant, R.F., Good, G.E., Cook, S.W., O'Neil, J.M., Smalley, K.B., Owen, K., & Richmond, K. (2006). The normative male alexithymia scale: Measurement of a gender-linked syndrome. Psychology of Men and Masculinity, 7, 212-224.

Levant, R., Rankin, T.J., Williams, C.M., Hasan, N.T., & Smalley, K.B. (2010). Evaluation of the factor structure and construct validity of scores on the Male Role Norms Inventory – Revised (MRNI-R). Psychology of Men and Masculinity, 11, 25-37.

Levant, R.F., Richmond, K., Majors, R.G., Inclan, J.E., Rosello, J.M., Rowan, G., & Sellers, A. (2003). A multicultural investigation of masculinity ideology and alexithymia. Psychology of Men and Masculinity, 4. 91-99.

Mahalik, J.R., Good, G.E., & Englar-Carson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. Professional Psychology: Research and Practice, 34, 123-131.

McKelley, R. A., & Rochlen, A. B. (2010). Conformity to masculine role norms and preferences for therapy or executive coaching. Psychology of Men and Masculinity, 11, 1-14.

Mendoza, J., & Cummings, A.L. (2001). Help-seeking and male gender-role attitudes in male batterers. Journal of Interpersonal Violence, 16, 833-840.

Men's Health Forum. (2006a). Mind your head: Men, boys and mental wellbeing. London: Men's Health Forum.

Men's Health Forum. (2006b). *The report of the gender equity project: What the 'Gender Duty' provision of the Equality Act 2006 will mean for the health of men.* London: Men's Health Forum.

Men's Health Forum. (2010). Untold problems: A review of the essential issues in the mental health of men and boys. London: Men's Health Forum.

Men's Health Forum. (2011). Delivering male: Effective practice in male mental health. London: Men's Health Forum.

Mind. (2009). Men and mental health: Get it off your chest. London: Mind.

NHS Information Centre. (2009). Trends in consultation rates in general practice 1995 to 2008: Analysis of the QResearch database. London: Department of Health.

NHS Information Centre. (2010). In-patients formally detained in hospitals under the mental health act 1983 and patients subjected to supervised community treatment, annual figures, England 2009/10. Retrieved from http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/inpatientdetmha0910/KP90_final_report.pdf

NIMHE. (2008). Suicide prevention strategy for England: Annual report on progress 2007. London: Department of Health.

O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate": Men's accounts of masculinity and help seeking. Social Science and Medicine, 61, 503-516.

O'Brien, O., & White, A. (2003). Gender and health: The case for gender-sensitive health policy in health care delivery (conference paper for 14 November 2003). Retrieved from http://www.emhf.org/resource_images/GaHP_Briefing_Paper.pdf

O'Neil, J. M. (1981). Male sex-role conflict, sexism, and masculinity: Implications for men women, and the counseling psychologist. The Counseling Psychologist, 9, 61-80.

O'Neil, J. (2008). Summarising 25 years of research on men's gender role conflict using the gender role conflict scale. The Counseling Psychologist, 36, 358-445.

Ogden, T.H. (1989). The primitive edge of experience. Northvale, NJ: Aronson.

Office of National Statistics. (2004). Consultations with an NHS GP: By sex and age, 2001/02: Social Trends 34 2004. Retrieved from http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=7401&;More=Y

Office of National Statistics. (2010). Patterns of specialist mental health service usage in England. Retrieved from http://neighbourhood.statistics.gov.uk/HTMLDocs/images/Mental-Health-Service-usage-small-analysis1_tcm97-97434.pdf

Pattman, R., Frosh, S., & Phoenix, A. (2005). Constructing and experiencing boyhoods in research in London. Gender and Education, 17(5), 555-561.

Pevalin, D., & Rose, D. (2003). Social capital for health: Investigating the link between social capital and health using the British household panel survey. London: Health Development Agency.

Pleck, J.H. (1981). The myth of masculinity. Cambridge, MA: MIT Press.

Pleck, J.H. (1995). The gender role strain paradigm: An update. In R.F. Levant & W.S. Pollack (Eds.), A new psychology of men (pp. 11-32). New York: Basic Books.

Pleck, J.H., Freya, L., & Leighton, C. (1994). Attitudes towards male role among adolescent male: A discriminant validity analysis. Sex Roles, 30, 481-501.

Pollack, W.S. (1995). No man is an island: Toward a new psychoanalytic psychology of men. In R. Levant & W. Pollack (Eds.), A new psychology of men (pp. 68-90). New York: Basic Books.

Pollack, W.S. (1998). The trauma of Oedipus: Toward a new psychoanalytic psychotherapy for men. In W.S. Pollack & R.F. Levant (Eds.), New Psychotherapy for Men (pp.13-34). Toronto: John Wiley & Sons.

Pollack, W. S., & Levant, R. F. (1998). New psychotherapy for men. New York: Wiley.

Price, B.K., & McNeill, B.W. (1992). Cultural commitment and attitudes towards seeking counseling services in American Indian college students. Professional Psychology: Research and Practice, 23, 376-381.

Prison Reform Trust. (2005). The prison factfile. London: Prison Reform Trust.

Richard, F.D., Bond, C.F., Jr., & Stokes-Zoota, J.J. (2003). One hundred years of social psychology quantitatively described. Review of General Psychology, 7(4), 331-363.

Ritchie, D. (1999). Young men's perceptions of emotional health: Research into practice. Health Education, 2, 70-75.

Robertson, J.M. & Fitzgerald, L.F. (1992) Overcoming the masculine mystique: Preferences for alternative forms of assistance amongst men who avoid counseling. Journal of Counseling Psychology, 39, 240-246.

Rochlen, A. B., Whilde, M.R., & Hoyer, W. D. (2005). The real men. Real depression campaign: Overview, theoretical implications, and research considerations. Psychology of Men and Masculinity, 6, 186-194.

Samaritans. (2010). Men on the ropes campaign. Retrieved from http://www.samaritans.org/support_samaritans/campaigns/boxer_campaign_2010/boxer_campaign_about.aspx

Sanchez, A.R., & Atkinson, D.R. (1983). Mexican-American cultural commitment, preference for counselor ethnicity, and willingness to use counseling. Journal of Counseling Psychology, 30, 215-220.

Simonsen, G., Blazina, C., & Watkins, C.E. (2000). Gender role conflict and psychological well-being among gay men. Journal of Counseling Psychology, 47, 85-89.

The Scottish Government. (2009). GP Access Survey: Results and Methodology. Retrieved from http://www.scotland.gov.uk/Resource/Doc/277888/0083493.pdf

White, A. (2001). Report o*n the scoping study on men's Health.* London: HMSO.

Wisch, A.F., Mahalik, J.R., Hayes, J.A., & Nutt, E.A. (1995). The impact of gender role conflict and counselling technique on psychological help seeking in men. Sex Roles, 33,   77-89.

Critical Appraisal

Word Count: 1988

Q1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Before embarking on this project I worked up two other proposals that fell through because of sampling and logistical difficulties. Although disappointing I did learn from experiencing firsthand the difficulties one can come up against when trying to develop research ideas. I returned to my own ideas and interests, worked up a project and found a supervisor in an area traditionally overlooked by clinical psychology. This involved considerable effort and perseverance. Writing a research proposal, applying for funding and submitting the proposal for ethical approval provided me with experience of the professional research process. I developed sensitivity to ethical considerations and familiarity with using research governance frameworks, including the BPS Code of Conduct (BPS, 2009).

I have learnt how to develop search strategies and carry out literature reviews of the extant literature on a specific area of investigation. Critically evaluating and synthesising the evidence enabled me to identify gaps in an area of enquiry and develop research questions that were timely and of importance clinically and theoretically. Developing and constructing my own research questions has been an achievement and I believe I have gained an advanced and critical understanding of the strengths and limitations of online survey methodologies.

Independently researching how to conduct surveys online, I discovered the importance of developing a website concept and design that encourages people to take part, particularly when sampling from the general population. The concept and design was labour intensive and took several months to complete. Drawing up a timetable helped me to keep on

track. I have also learnt about some of the legalities, including those associated with free prize draws.

Using multiple regression analysis has enabled me to advance my understanding of this particular technique. Overcoming challenges in analysing the data has taken my research abilities to another level. Managing a large dataset was demanding and I have learnt the value of regularly backing up data. I feel more confident using SPSS and learnt, among other things, how to write syntax.

Interpreting the data in accordance with a priori hypotheses helped structure the write up and avoid data mining. By defining hypotheses in accordance with the evidence base I have hopefully remained unbiased in my interpretations and drawn conclusions that are within the limitations of the study.

Having completed an MSc in research methods and been taught research skills on the clinical psychology course I feel that I have good theoretical understanding of psychological research methods. However, I am less experienced in using some methodologies and would like to further develop my skills. Remaining practiced and involved in research will help me to develop further and will form part of my continued professional development.

Q2. If you were able to do this project again, what would you do differently and why?

Using the Internet to carry out research was new to me and I made many discoveries along the way. The Internet moves so quickly and many texts on conducting online research appeared dated within a few years. I found talking to people who worked with the web resources particularly beneficial when developing sampling strategies. Because this was a process of discovery I found myself frequently thinking about things I could have done differently.

Through my research I discovered additional online tools that enabled me to monitor the effectiveness of my sampling strategies. Some strategies proved more effective than others with the most effective sampling strategy only indentified half way through the data collection. Given this information, if I was able to carry out the study again, I believe that I would be able to obtain a more representative sample. I hope to write a journal article of my experiences and strategies for publication in the Clinical Psychology Forum that could help other clinical psychologists make use of Internet-based research.

Google analytics also provided me with insight into one particular limitation of the study. Forty-seven-percent of the people who found the site decided not to take part. It would have been useful to have information about these people to compare with the rest of the sample population. In retrospect I would now include an additional pop-up page for the person leaving to record some basic demographic information. This would have been accompanied with information about why this was important. However, including this option is unlikely to solve this issue completely and I am sure that it will continue to be a limitation of online survey methodologies.

The measure of age used was categorical instead of continuous which reduced the power of the overall statistical analysis. Measuring age in this way was one of my main oversights during the design stage. In addition to this I struggled to obtain a useful way to define social class. Although I did include a measure of occupation the options did not correspond accurately enough to the Standard Occupational Classification (2010) published by the Office for National Statistics.

A decision was made to only sample men from the UK to keep the research focused. However, it would have been useful to have a small sample of women to compare and

contrast their scores on the measures used. The global reach of the Internet survey was of interest and sampling globally appears to be something that is relatively easy to achieve. Knowing now that it is possible to store data in a format that enables the researcher to manage large datasets has given me confidence to think on a larger scale.

Q3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?

Whilst embarking on this journey I broadened my professional network and developed good working relationships with people interested in men's mental health. In addition to studying on the course I have worked with the Men's Health Forum (MHF) and Mind on 'Delivering Male' (MHF, 2011), evaluated a men's group, set up a men's mental health network with two other psychologists, been invited to attended an all party parliamentary group on men's mental health and been asked to consult with Richmond Mind regarding workshops on men's mental health. Most of this work has been aimed at raising awareness of men's mental health.

In our men's mental health network we have approached the BPS with regards to forming a section on men's health which has not yet been met with great enthusiasm. We aim to develop our ideas and hopefully in the near future we can link with the women's section of the BPS to create a more integrated psychology of gender.

Research that is gender sensitive is only just beginning and the psychology of men needs to become intertwined with the psychology of women. This has not been the case to date but there is no doubt in my mind that men's mental health impacts on women and vice versa. To look at either in isolation would be an injustice to the psychology of gender. This is an exciting area for me and one in which I will be interested for many years to come.

From undertaking this work and combined with my previous experience working specifically with men's issues, I believe that I have developed specialist knowledge and skills in this particular area. I now incorporate a psychology of men and masculinity into my own clinical work. Within clinical case discussions I raise men's issues and frame them within the psychological knowledge base. In my current placement I am setting up and running a men's group. In the future I hope to provide teaching and training with my colleagues from the men's mental health network and we have already discussed this as one aim of the group.

There are some important clinical issues that have been brought to mind from carrying out the literature review and research. Firstly, at a primary care level men are underutilising IAPT services and seem to engage less in preventative/maintenance health strategies. Services need to think about how to motivate men to use services and have a duty to address this (MHF, 2006). There are a number of possibilities for future research in this area including; understanding men's experiences of psychological distress and their tendency to externalise problems; the gender sensitivity of diagnostic category and symptomatology profiles; how to identify men in psychological distress; and the acceptability of services.

When men do access services they may face unique difficulties that services are not yet sensitive to. For example, men may be faced with overcoming fearful expectations about what therapy involves. How to get men to seek help and helping them to engage and stay engaged is of key importance. Although it is unclear how to achieve this some authors (Conrad & White, 2010; McKelley & Rochlen, 2007; MHF, 2011; Rochlen, Whilde & Wayne, 2005) have offered ideas although little is known about their effectiveness (Addis & Cohane, 2010).

Q4. If you were to undertake further research is this area what would that research project seek to answer and how would you go about doing it?

There are some very straightforward questions that I would have liked to have addressed but was unable to given the limitations of the sample. For example, it is not clear whether men and women actually differ in their rates of normative alexithymia or in their fear of intimacy with regards to the scales used. Obtaining a comparative sample of women would have helped to answer these additional questions.

I am particularly interested in the reluctance of men to engage with services voluntarily or until problems are so severe that interventions become coercive. I would like to find new and novel ways to motivate men to seek help and support when they need to. Initiatives such as 'Sort Out Stress' (2010) and 'Men on the Ropes' (Samaritans, 2010) have attempted to reach men but their impact is not known and future research could investigate how such initiatives are received by men and whether they lead to changes in help seeking.

Within this study I focused on professional help seeking, which is often the last resort for both men and women (Gourash, 1978). People often prefer to first seek help from friends, families or others within their communities such as religious leaders. Within the UK many men struggle to build supportive networks in their communities (Boreham, Stafford & Taylor, 2000; Pevalin & Rose, 2003. My interest in community psychology helps me to see the potential for clinical psychologists to move into community based preventative mental health initiatives. I have already been in contact with my local MP with regards to learning more about the prime minister's 'Big Society' policy. I try to use these principles within my personal life and our community participates each year in the 'Big Lunch'. We have also set up women's and men's nights to try to maintain an engaged and active community. Little is

known about the impact of such initiatives but I believe they could have an enormous impact on men's mental health.

Although men show least preference for men's groups compared to individual therapy and psycho-education (Blazina & Marks, 2001) in my experience they can be hugely beneficial. However, men's groups are much less common than women's groups, particularly within the NHS. Future research into the effectiveness of men's groups is needed and I hope to be involved in the evaluation of different men's groups in the future.

Gender differences appear to exist between men and women in their experiencing of emotion and intimacy (Hook, Gerstein, Detterich & Gridley, 2003; Kring & Gordon, 1998). However, the exact nature of these differences or the processes through which they develop are not well understood. More research is needed before we understand how men develop certain difficulties and whether these difficulties represent a socially constructed restriction, an underlying deficit or indeed both.

References

Addis, M.E., & Cohane, G.H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men's mental health. Journal of Clinical Psychology, 61, 633-647.

Blazina, C., & Marks, L.J. (2001). College men's affective reactions to individual therapy, psychoeducational workshops, and men's support group brochures: The influence of gender-role conflict and power dynamic upon help-seeking attitudes. Psychotherapy, 38, 297-305.

Boreham, R., Stafford, M., & Taylor, R. (2000). Health survey for England: Social capital and health. London: The Stationary Office.

British Psychological Society. (2009). Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_ethics_and_conduct.pdf

Conrad, D., & White, A. (Eds.). (2010). *Promoting men's mental health*. Oxford: Radcliffe Publishing.

Gourash, N. (1978). Help seeking: A review of the literature. American Journal of Community Psychology, 6, 413-423.

Hook, M.K., Gerstein, L.H., Detterich, L., & Gridley, B. (2003). How close are we? Measuring intimacy and examining gender differences. Journal of Counseling and Development, 81, 462-472.

Kring, A.M., & Gordon, A.H. (1998). Sex differences in emotion: Expression, experience and physiology. Journal of Personality and Social Psychology, 74, 686-703.

McKelley, R.A., & Rochlen, A.B. (2007). The practice of coaching: Exploring alternatives to therapy for counseling-resistant men. Psychology of Men and Masculinity, 8(1), 53-65.

Men's Health Forum. (2006). *The report of the gender equity project: What the 'Gender Duty' provision of the Equality Act 2006 will mean for the health of men.* London: Men's Health Forum.

Men's Health Forum. (2011). Delivering male: Effective practice in male mental health. London: Men's Health Forum.

ONS. (2010). Standard Occupational Classification 2010. Retrieved from http://www.ons.gov.uk/about-statistics/classifications/current/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html#1

Pevalin, D., & Rose, D. (2003). Social capital for health: Investigating the link between social capital and health using the British household panel survey. London: Health Development Agency.

Rochlen, A. B., Whilde, M.R., & Hoyer, W. D. (2005). The real men. Real depression campaign: Overview, theoretical implications, and research considerations. Psychology of Men and Masculinity, 6, 186-194.

Sort Out Stress. (2010). Sort Out Stress. Retrieved from http://www.sortoutstress.co.uk/site

Samaritans. (2010). Men on the ropes campaign. Retrieved from http://www.samaritans.org/support_samaritans/campaigns/boxer_campaign_2010/boxer_campaign_about.aspx

Appendix 1: Literature review search methodology

A systematic search was carried out using PsychINFO, Medline, CCCU Journals, EBM reviews and CINAHL between 1980 and 2011. The search term help seeking was used and mapped to the PsychINFO subject headings: Health Care Seeking Behavior; Help Seeking Behavior and; Treatment Barriers. The terms mental health, psychological, psychology, psychotherapy and counselling were mapped to the associated subject headings. These two searches were combined using the 'and' function. The search was limited to journal articles published in the English language. In total, 98 articles were returned from the search and 19 were considered appropriate for inclusion in the review. Subsequent searches were carried out in Medline, CCCU Journals, EBM reviews and CINAHL. Articles were read and references searched. A further 13 journal articles were found that were specific to this review.

Appendix 3: Website design sample images
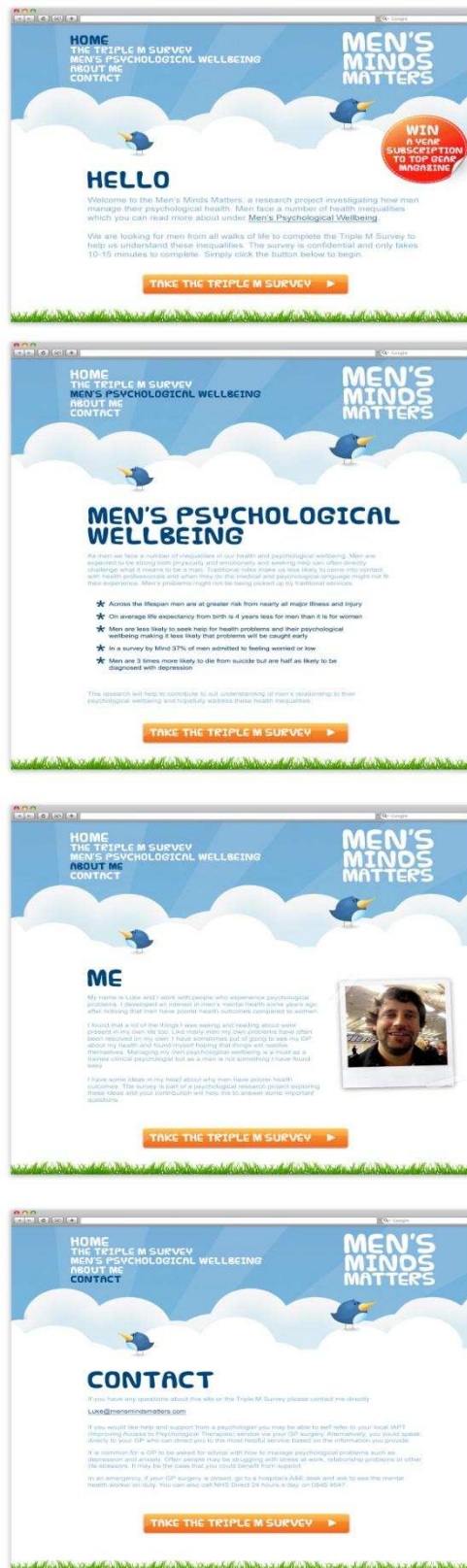
N.B Please not that these are sample images and the wording has been adapted for the main site in accordance with feedback the pilot study group.

Appendix 4: Website Consent Page

Appendix 7: Postcard/business card campaign

Front

Back

Appendix 8: Introductory email to trainee clinical psychologists

Dear trainees,

Allow me to introduce myself. My name is Luke Sullivan; I am a trainee clinical psychologist currently in my final year in the Department of Applied Psychology's clinical psychology programme at Canterbury Christ Church University. As part of my training I am carrying out a psychological research project which aims to address inequalities men face in the context of their health and mental wellbeing.

I have developed an online, anonymous survey which is hosted on the website: www.mensmindsmatter.com <http://www.mensmindsmatter.com>. I'm asking that people help raise awareness about the research by emailing male friends and family members which you could do by forwarding this email with a link to the site and a short message.

You can also support the research on facebook <http://www.facebook.com/pages/Mens-Minds-Matter/153249834713807> and twitter <http://twitter.com/mensmindsmatter>and there are links on the site to take you to the relevant pages.

I am hoping that men of all ages and backgrounds will complete the survey which has been approved by the Ethics Committee from the Salomons Campus at Canterbury Christ Church University. The survey takes 10-15 minutes to complete and you can enter a prize draw to win an Ipod Nano.

If you do feel that you would like to complete the survey yourself please use the link above.

Thanking you in advance.

Sincerely,

Luke Sullivan

Trainee Clinical Psychologist

Department of Applied Psychology

Canterbury and Christ Church University

Email: Luke@mensmindsmatter.com

Appendix 9: Demographics questionnaire

Age	18 -25	26-35	36-45	46-55	56-65	Over 65							
Gender	Male	Female											
Ethnicity	White	Mixed	Asian or Asian British	Black or Black British	Chinese or Other Ethnic Groups								
Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other						
Marital status	Single	Married	Seperated	Cohabiting	Widowed	Divorced	Other						
Sexuality	Gay	Heterosexual											
Educational acheivements	GCSEs/CSEs/O levels	A levels/AS levels/NVQ/GNVQ/Diploma	Degree	Professional Qualifications (eg. teaching, nursing, accountancy)	Post-Graduate								
Employment Status	Employed	Self-Employed	Retired	House-Person	Contractor	Temporary	Student	Looking for Work	Other				
Occupation	List of occupations												
Income	£0 - 15000	£15001 - 25000	£25001 - 35000	£35001 - 45000	£45001 - 60000	£60001 - 80000	£80001+						
Residential status	Council Tenent	In Student Housing	Joint Owner	Living with Parents	Owner	Private Tenent							
Are you a permenant UK resident	Yes	No											
Nationality	List of countries												
How did you find the site?	Online search	Friend	Link from another site	Internet Blog	Twitter	Facebook	Other social networking site	Email	Leaflet	Magazine	Newspaper	Other	
Have you ever received support from your GP for your psychological health?	Yes	No											
Have you ever received support from a mental health professional?	Yes	No											

Appendix 14: Test for skewness, kurtosis and normality

MRAS total score

Mean =16.72
Std. Dev. =3.157
N =570

Normal P-P Plot of MRAS total score

NMAS total score

Mean =3.73
Std. Dev. =1.143
N =519

Normal P-P Plot of NMAS total score

FOI total score

Mean =86.43
Std. Dev. =25.168
N =460

Normal P-P Plot of FOI total score

ATSPPH total score

Mean =17.52
Std. Dev. =5.97
N =505

Normal P-P Plot of ATSPPH total score
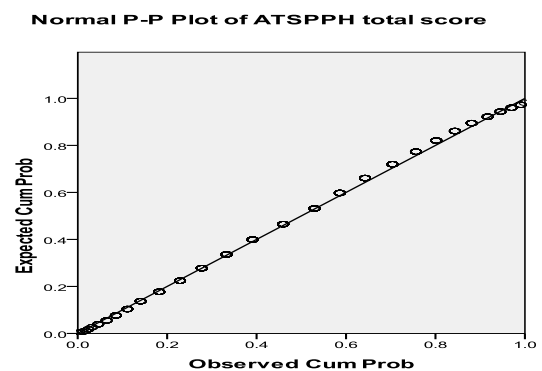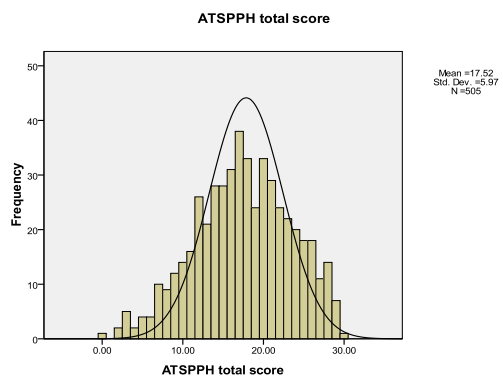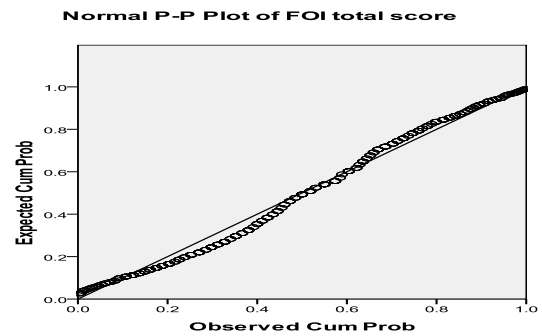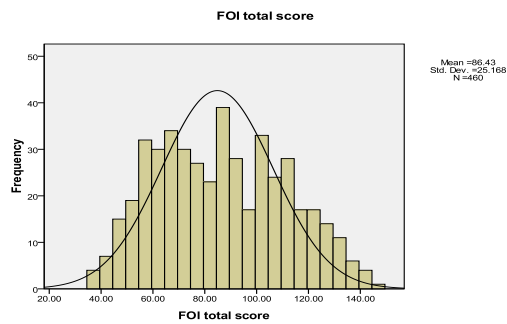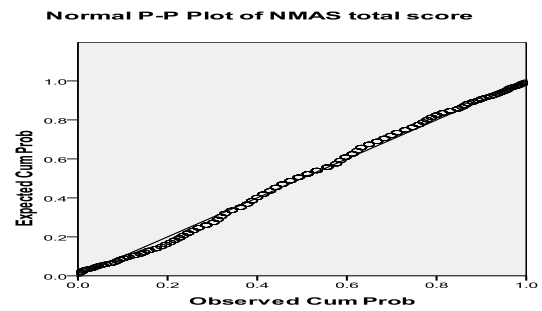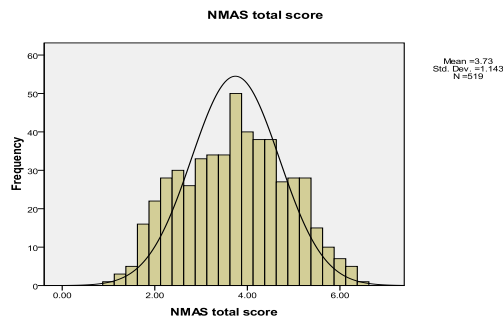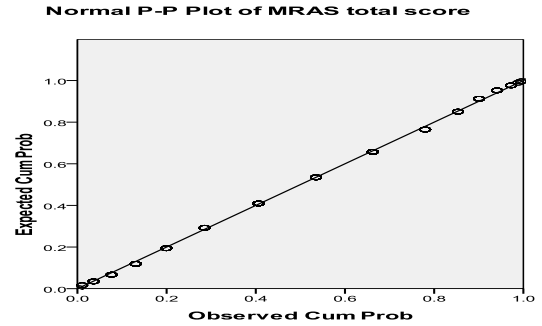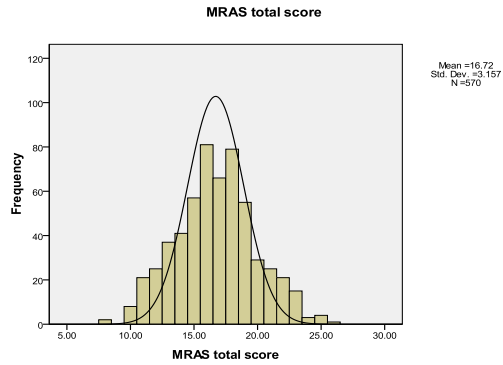
Statistics

		MRAS total score	NMAS total score	FOI total score	ATSPPH total score
N	Valid	570	519	460	505
	Missing	42	93	152	107
Mean		16.7228	3.7341	86.4348	17.5228
Std. Error of Mean		.13222	.05015	1.17348	.26565
Median		17.0000	3.7500	86.0000	18.0000
Mode		16.00	3.90	89.00	17.00
Std. Deviation		3.15677	1.14256	25.16841	5.96983
Variance		9.965	1.305	633.449	35.639
Skewness		.080	.012	.183	-.215
Std. Error of Skewness		.102	.107	.114	.109
Kurtosis		-.148	-.695	-.883	-.388
Std. Error of Kurtosis		.204	.214	.227	.217
Range		18.00	5.60	109.00	30.00
Minimum		8.00	1.00	37.00	.00
Maximum		26.00	6.60	146.00	30.00
Sum		9532.00	1938.00	39760.00	8849.00
Percentiles	25	15.0000	2.8500	66.0000	13.5000
	50	17.0000	3.7500	86.0000	18.0000
	75	19.0000	4.5500	106.0000	22.0000

ZSkewness

MRAS: .080 / .102 = .78
NMAS: .012 / .107 = 1.12
FOI: .183 / .114 = 1.61
ATSPPH: -.215 / .109 = -1.97*

ZKurtosis

MRAS: -.148 / .204 = .73
NMAS: -.695 / .214 = 3.25**
FOI: -.883 / .227 = -3.89***
ATSPPH: -.388 / .217 = -1.78
* sig @ P<0.05 ** sig @ P<0.01 *** sig @ P<0.001 (nb significance levels should

not be used in large samples >200. Visual checks and scores should be considered)

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
MRAS total score	.079	44	.000	.985	44	.000
NMAS total score	.048	44	.015	.986	44	.000
ATSPPH total score	.048	44	.018	.988	44	.001
FOI total score	.064	44	.000	.977	44	.000

a. Lilliefors Significance Correction

Tests indicate a distribution significantly different from would be expected in a

normal distribution. However, when using larger samples it is very easy to get a significant

result from small deviations from normal.

Appendix 15: Correlations between demographic, predictor and outcome variables

		Age	Non-British	Religious	Single	Education	Unemployed	Income	Sexuality	MRAS total score	NMAS total score	FOI total score	ATSPPH total score
Age	Pearson Correlation	1	0.019	-0.011	-.323**	.097*	-.168**	.332**	-.077*	-.131**	-0.065	-0.058	.091*
	Sig. (1-tailed)		0.322	0.405	0	0.013	0	0	0.037	0.001	0.076	0.114	0.025
	N	575	571	451	554	532	554	561	543	535	484	430	472
Non-British	Pearson Correlation	0.019	1	0.05	-0.004	.161**	0.043	0.04	0.064	.086*	-0.068	-0.048	.120**
	Sig. (1-tailed)	0.322		0.143	0.464	0	0.156	0.174	0.067	0.024	0.068	0.159	0.004
	N	571	577	454	556	534	556	560	543	536	485	431	473
Religious	Pearson Correlation	-0.011	0.05	1	0	-0.058	-0.011	-0.048	0.007	.155**	-.112*	-.097*	0.039
	Sig. (1-tailed)	0.405	0.143		0.499	0.117	0.413	0.156	0.441	0.001	0.015	0.036	0.227
	N	451	454	456	442	419	437	446	428	424	381	341	375
Single	Pearson Correlation	-.323**	-0.004	0	1	-0.064	.162**	-.292**	.163**	0.022	.121**	.325**	-0.019
	Sig. (1-tailed)	0	0.464	0.499		0.071	0	0	0	0.305	0.004	0	0.344
	N	554	556	442	560	521	541	545	528	522	471	417	459
Educational achievement	Pearson Correlation	.097*	.161**	-0.058	-0.064	1	-.144**	.285**	0.06	-.135**	-.121**	-.109*	0.04
	Sig. (1-tailed)	0.013	0	0.117	0.071		0.001	0	0.09	0.001	0.005	0.014	0.2
	N	532	534	419	521	537	520	524	506	501	454	402	443
Unemployed	Pearson Correlation	-.168**	0.043	-0.011	.162**	-.144**	1	-.340**	-0.016	0.034	0.05	.091*	0.007
	Sig. (1-tailed)	0	0.156	0.413	0	0.001		0	0.359	0.217	0.139	0.031	0.436
	N	554	556	437	541	520	560	544	531	521	472	422	461
Income	Pearson Correlation	.332**	0.04	-0.048	-.292**	.285**	-.340**	1	-.109**	-.073*	-.076*	-.146**	0.03
	Sig. (1-tailed)	0	0.174	0.156	0	0	0		0.006	0.047	0.049	0.001	0.262
	N	561	560	446	545	524	544	564	535	526	477	424	465
Sexuality	Pearson Correlation	-.077*	0.064	0.007	.163**	0.06	-0.016	-.109**	1	-0.034	-0.022	.116**	.122**

Appendix 15: Correlations between demographic, predictor and outcome variables

	Sig. (1-tailed)	0.037	0.067	0.441	0	0.09	0.359	0.006		0.221	0.317	0.01	0.005
	N	543	543	428	528	506	531	535	547	508	458	408	447
MRAS total score	Pearson Correlation	-.131**	.086*	.155**	0.022	-.135**	0.034	-.073*	-0.034	1	.336**	.202**	-.267**
	Sig. (1-tailed)	0.001	0.024	0.001	0.305	0.001	0.217	0.047	0.221		0	0	0
	N	535	536	424	522	501	521	526	508	539	488	434	476
NMAS total score	Pearson Correlation	-0.065	-0.068	-.112*	.121**	-.121**	0.05	-.076*	-0.022	.336**	1	.772**	-.293**
	Sig. (1-tailed)	0.076	0.068	0.015	0.004	0.005	0.139	0.049	0.317	0		0	0
	N	484	485	381	471	454	472	477	458	488	488	434	476
FOI total score	Pearson Correlation	-0.058	-0.048	-.097*	.325**	-.109*	.091*	-.146**	.116**	.202**	.772**	1	-.218**
	Sig. (1-tailed)	0.114	0.159	0.036	0	0.014	0.031	0.001	0.01	0	0		0
	N	430	431	341	417	402	422	424	408	434	434	434	434
ATSPPH total score	Pearson Correlation	.091*	.120**	0.039	-0.019	0.04	0.007	0.03	.122**	-.267**	-.293**	-.218**	1
	Sig. (1-tailed)	0.025	0.004	0.227	0.344	0.2	0.436	0.262	0.005	0	0	0	
	N	472	473	375	459	443	461	465	447	476	476	434	476

**. Correlation is significant at the 0.01 level (1-tailed), *. Correlation is significant at the 0.05 level (1-tailed).

Spearman's rho		Age	Non-British	Religious	Single	Educational achievement	Unemployed	Income	Sexuality	MRAS total score	NMAS total score	FOI total score	ATSPPH total score
Age	Correlation Coefficient	1	0.026	-0.012	-.340**	.125**	-.246**	.381**	-0.067	-.137**	-0.05	-.080*	.098*
	Sig. (1-tailed)	.	0.271	0.4	0	0.002	0	0	0.06	0.001	0.134	0.049	0.017
	N	575	571	451	554	532	554	561	543	535	484	430	472
Non-British	Correlation Coefficient	0.026	1	0.05	-0.004	.163**	0.043	0.039	0.064	0.07	-0.067	-0.05	.117**
	Sig. (1-tailed)	0.271	.	0.143	0.464	0	0.156	0.18	0.067	0.053	0.07	0.149	0.006
	N	571	577	454	556	534	556	560	543	536	485	431	473
Religious	Correlation Coefficient	-0.012	0.05	1	0	-0.051	-0.011	-0.021	0.007	.158**	-.117*	-.099*	0.046
	Sig. (1-tailed)	0.4	0.143	.	0.499	0.148	0.413	0.331	0.441	0.001	0.011	0.034	0.187
	N	451	454	456	442	419	437	446	428	424	381	341	375
Single	Correlation Coefficient	-.340**	-0.004	0	1	-.072*	.162**	-.317**	.163**	0.031	.116**	.325**	-0.025
	Sig. (1-tailed)	0	0.464	0.499	.	0.05	0	0	0	0.243	0.006	0	0.297
	N	554	556	442	560	521	541	545	528	522	471	417	459
Educational achievement	Correlation Coefficient	.125**	.163**	-0.051	-.072*	1	-.163**	.344**	0.06	-.127**	-.115**	-.122**	0.054
	Sig. (1-tailed)	0.002	0	0.148	0.05	.	0	0	0.088	0.002	0.007	0.007	0.127
	N	532	534	419	521	537	520	524	506	501	454	402	443
Unemployed	Correlation Coefficient	-.246**	0.043	-0.011	.162**	-.163**	1	-.384**	-0.016	0.03	0.042	.084*	0.001
	Sig. (1-tailed)	0	0.156	0.413	0	0	.	0	0.359	0.249	0.181	0.043	0.494
	N	554	556	437	541	520	560	544	531	521	472	422	461
Income	Correlation Coefficient	.381**	0.039	-0.021	-.317**	.344**	-.384**	1	-.106**	-.088*	-.087*	-.163**	0.04
	Sig. (1-tailed)	0	0.18	0.331	0	0	0	.	0.007	0.021	0.029	0	0.198
	N	561	560	446	545	524	544	564	535	526	477	424	465
Sexuality	Correlation Coefficient	-0.067	0.064	0.007	.163**	0.06	-0.016	-.106**	1	-0.026	-0.021	.122**	.120**

Appendix 15: Correlations between demographic, predictor and outcome variables

	Sig. (1-tailed)	0.06	0.067	0.441	0	0.088	0.359	0.007	.	0.283	0.324	0.007	0.006
	N	543	543	428	528	506	531	535	547	508	458	408	447
MRAS total score	Correlation Coefficient	-.137**	0.07	.158**	0.031	-.127**	0.03	-.088*	-0.026	1	.331**	.223**	-.261**
	Sig. (1-tailed)	0.001	0.053	0.001	0.243	0.002	0.249	0.021	0.283	.	0	0	0
	N	535	536	424	522	501	521	526	508	539	488	434	476
NMAS total score	Correlation Coefficient	-0.05	-0.067	-.117*	.116**	-.115**	0.042	-.087*	-0.021	.331**	1	.769**	-.298**
	Sig. (1-tailed)	0.134	0.07	0.011	0.006	0.007	0.181	0.029	0.324	0	.	0	0
	N	484	485	381	471	454	472	477	458	488	488	434	476
FOI total score	Correlation Coefficient	-.080*	-0.05	-.099*	.325**	-.122*	.084*	-.163*	.122**	.223**	.769**	1	-.223*
	Sig. (1-tailed)	0.049	0.149	0.034	0	0.007	0.043	0	0.007	0	0	.	0
	N	430	431	341	417	402	422	424	408	434	434	434	434
ATSPPH total score	Correlation Coefficient	.098*	.117**	0.046	-0.025	0.054	0.001	0.04	.120**	-.261**	-.298**	-.223*	1
	Sig. (1-tailed)	0.017	0.006	0.187	0.297	0.127	0.494	0.198	0.006	0	0	0	.
	N	472	473	375	459	443	461	465	447	476	476	434	476

Appendix 15: Correlations between demographic, predictor and outcome variables

		Age	Non-British	Religious	Single	Education	Unemployed	Income	Sexuality	MRAS total score	NMAS total score	FOI total score	ATSPPH total score
Age	Pearson Correlation	1	0.019	-0.011	-.323**	.097*	-.168**	.332**	-0.077	-.131**	-0.065	-0.058	.091*
	Sig. (2-tailed)		0.645	0.81	0	0.025	0	0	0.074	0.002	0.152	0.228	0.049
	N	575	571	451	554	532	554	561	543	535	484	430	472
Non-British	Pearson Correlation	0.019	1	0.05	-0.004	.161**	0.043	0.04	0.064	.086*	-0.068	-0.048	.120**
	Sig. (2-tailed)	0.645		0.286	0.928	0	0.312	0.348	0.134	0.048	0.136	0.317	0.009
	N	571	577	454	556	534	556	560	543	536	485	431	473
Religious	Pearson Correlation	-0.011	0.05	1	0	-0.058	-0.011	-0.048	0.007	.155**	-.112*	-0.097	0.039
	Sig. (2-tailed)	0.81	0.286		0.998	0.233	0.826	0.311	0.883	0.001	0.029	0.073	0.455
	N	451	454	456	442	419	437	446	428	424	381	341	375
Single	Pearson Correlation	-.323**	-0.004	0	1	-0.064	.162**	-.292**	.163**	0.022	.121**	.325**	-0.019
	Sig. (2-tailed)	0	0.928	0.998		0.143	0	0	0	0.609	0.009	0	0.687
	N	554	556	442	560	521	541	545	528	522	471	417	459
Educational achievement	Pearson Correlation	.097*	.161**	-0.058	-0.064	1	-.144**	.285**	0.06	-.135**	-.121**	-.109*	0.04
	Sig. (2-tailed)	0.025	0	0.233	0.143		0.001	0	0.179	0.002	0.01	0.028	0.401
	N	532	534	419	521	537	520	524	506	501	454	402	443
Unemployed	Pearson Correlation	-.168**	0.043	-0.011	.162**	-.144**	1	-.340**	-0.016	0.034	0.05	0.091	0.007
	Sig. (2-tailed)	0	0.312	0.826	0	0.001		0	0.719	0.434	0.279	0.063	0.873
	N	554	556	437	541	520	560	544	531	521	472	422	461
Income	Pearson Correlation	.332**	0.04	-0.048	-.292**	.285**	-.340**	1	-.109*	-0.073	-0.076	-.146**	0.03
	Sig. (2-tailed)	0	0.348	0.311	0	0	0		0.012	0.094	0.098	0.003	0.524

Appendix 15: Correlations between demographic, predictor and outcome variables

	N	561	560	446	545	524	544	564	535	526	477	424	465
Sexuality	Pearson Correlation	-0.077	0.064	0.007	.163**	0.06	-0.016	-.109*	1	-0.034	-0.022	.116*	.122**
	Sig. (2-tailed)	0.074	0.134	0.883	0	0.179	0.719	0.012		0.441	0.634	0.019	0.01
	N	543	543	428	528	506	531	535	547	508	458	408	447
MRAS total score	Pearson Correlation	-.131**	.086*	.155**	0.022	-.135**	0.034	-0.073	-0.034	1	.336**	.202**	-.267**
	Sig. (2-tailed)	0.002	0.048	0.001	0.609	0.002	0.434	0.094	0.441		0	0	0
	N	535	536	424	522	501	521	526	508	539	488	434	476
NMAS total score	Pearson Correlation	-0.065	-0.068	-.112*	.121**	-.121**	0.05	-0.076	-0.022	.336**	1	.772**	-.293**
	Sig. (2-tailed)	0.152	0.136	0.029	0.009	0.01	0.279	0.098	0.634	0		0	0
	N	484	485	381	471	454	472	477	458	488	488	434	476
FOI total score	Pearson Correlation	-0.058	-0.048	-0.097	.325**	-.109*	0.091	-.146**	.116*	.202**	.772**	1	-.218**
	Sig. (2-tailed)	0.228	0.317	0.073	0	0.028	0.063	0.003	0.019	0	0		0
	N	430	431	341	417	402	422	424	408	434	434	434	434
ATSPPH total score	Pearson Correlation	.091*	.120**	0.039	-0.019	0.04	0.007	0.03	.122**	-.267**	-.293**	-.218**	1
	Sig. (2-tailed)	0.049	0.009	0.455	0.687	0.401	0.873	0.524	0.01	0	0	0	
	N	472	473	375	459	443	461	465	447	476	476	434	476

**. Correlation is significant at the 0.01 level (2-tailed), *. Correlation is significant at the 0.05 level (2-tailed).

Appendix 15: Correlations between demographic, predictor and outcome variables

Spearman's rho		Age	Non-British	Religious	Single	Educational achievement	Unemployed	Income	Sexuality	MRAS total score	NMAS total score	FOI total score	ATSPPH total score
Age	Correlation Coefficient	1	0.026	-0.012	-.340**	.125**	-.246**	.381**	-0.067	-.137**	-0.05	-0.08	.098*
	Sig. (2-tailed)	.	0.542	0.8	0	0.004	0	0	0.12	0.001	0.268	0.098	0.034
	N	575	571	451	554	532	554	561	543	535	484	430	472
Non-British	Correlation Coefficient	0.026	1	0.05	-0.004	.163**	0.043	0.039	0.064	0.07	-0.067	-0.05	.117*
	Sig. (2-tailed)	0.542	.	0.286	0.928	0	0.312	0.36	0.134	0.107	0.139	0.299	0.011
	N	571	577	454	556	534	556	560	543	536	485	431	473
Religious	Correlation Coefficient	-0.012	0.05	1	0	-0.051	-0.011	-0.021	0.007	.158**	-.117*	-0.099	0.046
	Sig. (2-tailed)	0.8	0.286	.	0.998	0.297	0.826	0.663	0.883	0.001	0.022	0.067	0.374
	N	451	454	456	442	419	437	446	428	424	381	341	375
Single	Correlation Coefficient	-.340**	-0.004	0	1	-0.072	.162**	-.317**	.163**	0.031	.116*	.325**	-0.025
	Sig. (2-tailed)	0	0.928	0.998	.	0.099	0	0	0	0.486	0.011	0	0.594
	N	554	556	442	560	521	541	545	528	522	471	417	459
Educational achievement	Correlation Coefficient	.125**	.163**	-0.051	-0.072	1	-.163**	.344**	0.06	-.127**	-.115*	-.122*	0.054
	Sig. (2-tailed)	0.004	0	0.297	0.099	.	0	0	0.175	0.004	0.014	0.014	0.255
	N	532	534	419	521	537	520	524	506	501	454	402	443
Unemployed	Correlation Coefficient	-.246**	0.043	-0.011	.162**	-.163**	1	-.384**	-0.016	0.03	0.042	0.084	0.001
	Sig. (2-tailed)	0	0.312	0.826	0	0	.	0	0.719	0.497	0.362	0.086	0.989
	N	554	556	437	541	520	560	544	531	521	472	422	461
Income	Correlation Coefficient	.381**	0.039	-0.021	-.317**	.344**	-.384**	1	-.106*	-.088*	-0.087	-.163**	0.04
	Sig. (2-tailed)	0	0.36	0.663	0	0	0	.	0.015	0.043	0.057	0.001	0.395
	N	561	560	446	545	524	544	564	535	526	477	424	465
Sexuality	Correlation Coefficient	-0.067	0.064	0.007	.163**	0.06	-0.016	-.106*	1	-0.026	-0.021	.122*	.120*
	Sig. (2-tailed)	0.12	0.134	0.883	0	0.175	0.719	0.015	.	0.565	0.648	0.013	0.011
	N	543	543	428	528	506	531	535	547	508	458	408	447
MRAS total score	Correlation Coefficient	-.137**	0.07	.158**	0.031	-.127**	0.03	-.088*	-0.026	1	.331**	.223**	-.261**
	Sig. (2-tailed)	0.001	0.107	0.001	0.486	0.004	0.497	0.043	0.565	.	0	0	0
	N	535	536	424	522	501	521	526	508	539	488	434	476

Appendix 15: Correlations between demographic, predictor and outcome variables

NMAS total score	Correlation Coefficient	-0.05	-0.067	-.117*	.116*	-.115*	0.042	-0.087	-0.021	.331**	1	.769**	-.298**
	Sig. (2-tailed)	0.268	0.139	0.022	0.011	0.014	0.362	0.057	0.648	0	.	0	0
	N	484	485	381	471	454	472	477	458	488	488	434	476
FOI total score	Correlation Coefficient	-0.08	-0.05	-0.099	.325**	-.122*	0.084	-.163**	.122*	.223**	.769**	1	-.223**
	Sig. (2-tailed)	0.098	0.299	0.067	0	0.014	0.086	0.001	0.013	0	0	.	0
	N	430	431	341	417	402	422	424	408	434	434	434	434
ATSPPH total score	Correlation Coefficient	.098*	.117*	0.046	-0.025	0.054	0.001	0.04	.120*	-.261**	-.298**	-.223**	1
	Sig. (2-tailed)	0.034	0.011	0.374	0.594	0.255	0.989	0.395	0.011	0	0	0	.
	N	472	473	375	459	443	461	465	447	476	476	434	476

Appendix 16: Regression analysis

Model		Unstandardized Coefficients B	Std. Error	Standardized Coefficients Beta	t	Sig.	95.0% Confidence Interval for B Lower Bound	Upper Bound	Correlations Zero-order	Partial	Part	Collinearity Statistics Tolerance	VIF
1	(Constant)	13.158	1.58		8.329	0	12.944	17.414					
	Age Binary	1.518	1.022	0.095	1.485	0.138	-.504	3.480	.081	.080	.078	.710	1.409
	Non-British	1.762	0.916	0.105	1.923	0.055	-.012	3.545	.120	.107	.104	.984	1.016
	Religious	0.399	0.675	0.032	0.59	0.555	-1.025	1.614	.039	.024	.023	.993	1.007
	Single	-0.095	0.704	-0.008	-0.134	0.893	-1.438	1.295	-.019	-.006	-.005	.847	1.181
	Education binary	0.328	1.03	0.018	0.319	0.75	1.188	10.634	.128	.134	.131	.968	1.033
	Income	0.309	0.745	0.025	0.414	0.679	-.898	2.004	.040	.041	.040	.766	1.305
	Sexuality	2.196	0.954	0.126	2.301	*.022	.269	3.991	.122	.123	.120	.963	1.038
	Unemployed	1.021	1.131	0.055	0.903	0.367	-1.006	3.407	.007	.059	.057	.780	1.282
2	(Constant)	20.403	2.404		8.487	0	18.450	26.767					
	Age Binary	1.178	0.969	0.074	1.216	0.225	-.747	3.029	.081	.065	.060	.700	1.429
	Non-British	1.864	0.872	0.111	2.136	*.033	.163	3.547	.120	.118	.108	.964	1.038
	Religious	0.48	0.653	0.038	0.734	0.463	-.861	1.687	.039	.035	.032	.943	1.061
	Single	0.17	0.715	0.014	0.238	0.812	-1.271	1.501	-.019	.009	.008	.730	1.370
	Education binary	0.76	0.975	0.041	0.78	0.436	1.433	10.380	.128	.142	.130	.957	1.045
	Income	-0.087	0.704	-0.007	-0.124	0.902	-1.258	1.488	.040	.009	.008	.759	1.318
	Sexuality	2.02	0.907	0.116	2.227	*.027	.170	3.708	.122	.118	.108	.945	1.058
	Unemployed	1.004	1.066	0.054	0.941	0.347	-.939	3.219	.007	.059	.054	.779	1.284
	MRAS total score	-0.405	0.107	-0.211	-3.804	**.000	-.628	-.212	-.267	-.214	-.200	.836	1.196

Appendix 16: Regression analysis

Zscore_average	-1.358	0.352		-0.213	-3.855	**.000	-1.962	-.583	-.272	-.196	-.182	.831	1.203
Zscore_difference	-0.472	0.491		-0.053	-0.961	0.337	-1.460	.454	-.112	-.057	-.052	.839	1.192

Masculinity, Alexithymia and Fear of Intimacy as Predictors of UK men's Attitudes Towards Seeking Professional Psychological Help

Aims

Men use psychological therapies less frequently than women and often delay seeking help until problems are more severe, if at all. Men's reluctance to seek help is considered to be the biggest factor associated with poorer health outcomes for men in the UK. Understanding men's help seeking is important in improving men's psychological health. Between the 7th September 2010 and the 15th January 2011 an online psychological study was conducted to find out whether masculine ideology, emotional awareness and intimacy were associated with UK men's attitudes towards seeking professional psychological help.

The Survey

Five hundred and eighty-one men decided to take part in the online survey at www.mensmindsmatter.com. The survey comprised of a measure of adherence to traditional masculine ideology, a measure of emotion (alexithymia), a fear of intimacy scale and a measure of attitudes towards seeking professional psychological help.

Results

The study found the following results:

- People who showed greater adherence to traditional masculine ideology reported more negative attitudes towards seeking psychological help.

- People who reported greater levels of alexithymia reported more negative attitudes towards seeking psychological help.

- A greater fear of intimacy was associated with more negative attitudes towards seeking psychological help.

- Alexithymia and fear of intimacy were closely related. Alexithymia was a stronger predictor of men's attitudes towards seeking psychological help than intimacy.

- People who were white British and hetero-sexual reported more negative attitudes towards seeking psychological help.

What next?

The implications of being socialised into the male world may be that some men experience difficulties recognising emotions and forming intimate connections with others in later life. Both of these factors were found to be associated with men's attitudes towards seeking psychological help. Adherence to traditional masculine ideology is associated with men's attitudes towards seeking psychological help. Specific groups of men may be more reluctant to seek help. In this study heterosexual white British men reported the most negative attitudes towards seeking professional psychological help. If we are to improve the psychological wellbeing of men we may need to find ways to legitimise help seeking amongst men. The ways in which men express their masculine selves as well as their emotional and interpersonal lives need to be considered when developing strategies that encourage men to seek help for psychological problems.